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991883 FEB 17 2000
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In the Supreme Court of the United States

U.S. HEALTHCARE, INC.,
Petitioner,

v.

STEVEN BAUMAN AND MICHELLE BAUMAN,
Individually and as Administrators *ad prosequendum*
of the Estate of Michelina Bauman, deceased,
Respondents.

Petition for a Writ of Certiorari
to the United States Court of Appeals
for the Third Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Petitioner is a health maintenance organization that administers an "employee benefit plan" within the meaning of Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a). Respondents' newborn daughter died of a strep infection one day after her discharge from the hospital. Respondents brought a negligence action in state court against petitioner based on petitioner's administrative pre-certification review policy of presumptively discharging newborn infants within twenty-four hours after a normal childbirth. Respondents did not allege that substandard medical care had been provided to their daughter at the hospital. Petitioner removed the lawsuit to federal court on the basis that respondents' claims were completely preempted by Section 502(a) of ERISA, 29 U.S.C. § 1132(a). The court of appeals held that none of respondents' claims was completely preempted, and remanded the case to state court.

The question presented is:

Does Section 502(a) of ERISA completely preempt negligence claims against a health maintenance organization that are based upon an administrative pre-certification review policy, rather than judgments or actions taken in the course of diagnosis or treatment?

RULE 14.1(b) AND 29.6 STATEMENT

Pursuant to Rule 14.1(b), petitioner U.S. Healthcare, Inc. states that the other parties to this action are plaintiffs Steven and Michelle Bauman and defendants Kennedy Memorial Hospital and Dr. Kamila Nemeh.

Pursuant to Rule 29.6, petitioner states that its parent company is Aetna, Inc.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner respectfully asks this Court to issue a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit.

OPINIONS BELOW

The opinion of the Third Circuit is reported at 193 F.3d 151. App. 1a-22a. The opinion of the District Court is reported at 1 F. Supp. 2d 420. App. 28a-39a.

JURISDICTION

The Third Circuit rendered its decision on September 16, 1999, and denied petitioner's petition for rehearing en banc on November 19, 1999. App. 42a-43a. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides that the laws of the federal government "shall be the supreme Law of the Land: any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. CONST. art. VI, cl. 2.

Section 502(a) of ERISA, 29 U.S.C. § 1132(a)(1)(B), provides:

> (a) A civil action may be brought —
>
> (1) by a participant or beneficiary —
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]

STATEMENT

A. Factual Background

Respondents Steven and Michelle Bauman were subscribers of the Health Maintenance Organization of New Jersey, Inc. ("HMO-NJ"),[1] which is a health maintenance organization that furnishes and administers health care benefits for plan participants pursuant to employee benefit plans established under ERISA. HMO-NJ administers this benefit plan by contracting with participating providers to provide health care services to plan subscribers for a pre-determined price. As a condition of coverage, subscribers agree to receive services from these participating providers, and pay a small co-payment and no deductible or co-insurance.

The complaint filed by respondents against petitioner, Kennedy Hospital, and Dr. Nemeh alleges that Michelle Bauman gave birth to a daughter, Michelina, at Kennedy Hospital on May 16, 1995.[2] App. 45a. Petitioner's then-existing pre-certification review policy provided for the presumptive discharge of newborn infants within twenty-four hours of a normal childbirth. *Id.* at 46a. Consistent with that policy, Dr. Nemeh, who was an independent health care provider contracting with HMO-NJ, discharged Mrs. Bauman and her daughter on May 17, 1995, the day after the birth. *Id.* at 49a. On May 18, the day after the baby was discharged and two days after her birth, the Baumans noticed that she was ill. *Ibid.* They made several telephone calls to Dr. Nemeh, reporting the baby's symptoms and expressing their concerns about her health. *Ibid.* Dr. Nemeh did not advise the Baumans to bring the baby back to the hospital for medical attention. *Ibid.* Respondents also allege that they called HMO-NJ to request an

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[1] HMO-NJ is a subsidiary of petitioner.

[2] Because this case was at the pleading stage when it came before the district court, petitioner recounts the facts as alleged in the complaint.

in-home visit by a pediatric nurse as provided under HMO-NJ's "L'il Appleseed Program," but such a visit was not made. *Id.* at 51a. Respondents' baby had contracted a Group B strep infection that developed into meningitis. *Id.* at 46a-47a. She died at home on May 18, 1995, the day after her discharge from the hospital. *Id.* at 47a.

B. Procedural History

Respondents filed their lawsuit in New Jersey Superior Court, Camden County, in May 1997. App. 54a. They sued petitioner, Kennedy Hospital, and Dr. Nemeh.

Five of the counts were brought against petitioner. In Count One, respondents alleged that petitioner acted negligently in adopting a policy that supposedly pressured participating providers to discharge newborns within twenty-four hours of birth without due care for their health. *Id.* at 46a-47a. Count Two alleged that petitioner adopted the twenty-four-hour discharge policy in reckless disregard of the health consequences of the policy and solely for profit. *Id.* at 47a. Count Five alleged that petitioner negligently adopted policies with respect to hospital utilization that discouraged participating physicians from re-admitting infants to the hospital when health problems arose after discharge. *Id.* at 50a. Count Six alleged that an in-home visit by a pediatric nurse was improperly denied to respondents even though it was a benefit they were entitled to receive under the terms of their health benefits plan and had specifically requested. *Id.* at 51a. Finally, Count Eight sought damages for emotional distress on account of an alleged breach of the duty to provide reasonable medical care. *Id.* at 53a-54a.

Petitioner removed the action to federal court on the ground that federal question jurisdiction existed under Section 502(a) of

ERISA pursuant to the complete preemption doctrine.[3] Respondents then moved to remand the case to state court. The district court held that removal of the case had been proper, because Count Six, relating to the failure to provide an in-home visit by a pediatric nurse as contemplated by the "L'il Appleseed Program," was completely preempted by Section 502(a) of ERISA. App. 37a. The court held that this claim fit within the civil enforcement provisions of Section 502(a), since it sought "to recover benefits due * * * under the terms of [the] plan," 29 U.S.C. § 1132(a)(1)(B). App. 37a. The court stated that, since Count Six was completely preempted under Section 502(a), it was also necessarily subject to merits preemption under Section 514(a), and therefore the court dismissed that claim. *Id.* at 38a. The district court held that none of the other claims was completely preempted by Section 502(a), and it exercised its discretion to remand them to state court under 28 U.S.C. § 1367(c)(3). *Id.* at 38a-39a.

On appeal, the Third Circuit held that none of the claims against petitioner was completely preempted, and it therefore reversed the dismissal of Count Six and ordered remand of the entire case to state court. *Id.* at 22a. In determining whether the claims were completely preempted, the Court relied on the "quality of care" versus "quantity of benefits" distinction it had drawn previously in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995). App. 13a-16a. In *Dukes*, the court had declared that state law claims directed to the quality of benefits provided are not completely preempted, whereas claims that "the plans erroneously withheld benefits

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[3] In *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), this Court held that Section 502(a) completely preempts claims that are ostensibly based on state law but that fall within the scope of the civil enforcement provisions of that statute, thus rendering those claims federal in nature. The Court stated that "Congress has clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) removable to federal court." *Id.* at 66.

due" or that seek "to enforce [plaintiffs'] rights under the terms of their respective plans" are completely preempted. 57 F.3d at 356.

The court rejected petitioner's argument that respondents' claims in Counts One and Two arising from the twenty-four-hour discharge precertification review policy represented a challenge to the quantity of benefits made available under the plan. App. 16a-18a. The court also held that the complete preemption doctrine did not apply to the claim in Count Five that petitioner had acted negligently in "adopting policies with respect to hospital utilization by its participating physicians that discouraged these physicians from re-admitting infants to the hospital," even though the court's earlier decision in *Dukes* stated (57 F.3d at 360-361) that Section 502(a) completely preempts utilization review challenges. App. 18a-20a. Finally, the court reversed the district court's determination that Count Six was completely preempted, concluding that petitioner's failure to provide an in-home visit by a pediatric nurse despite respondents' request and despite their entitlement to it under the "L'il Appleseed Program" did not constitute a claim to "recover benefits due * * * under the terms of [the] plan," 29 U.S.C. § 1132(a). App. 20a-22a. However, the court did concede that the complete preemption issue as to Count Six was "a close one," and the district court was not "unreasonable" in holding the claim to have been completely preempted. *Id.* at 21a.

REASONS FOR GRANTING THE PETITION

Since the beginning of this Term, this Court has had before it another case involving petitioner that presents the question whether claims arising from a health maintenance organization's alleged negligence in its administration of benefits under an ERISA-governed health plan are preempted by Section 514(a) of ERISA. *United States Healthcare Systems, Inc. v. Pennsylvania Hosp. Ins. Co.*, No. 98-1836. The issue of complete preemption under Section 502(a) of ERISA involved here, though somewhat different from the Section 514(a)

"merits" preemption issue involved in *United States Healthcare Systems*, is nevertheless closely related, because courts have correctly recognized that, where a claim is completely preempted under Section 502(a), it is also necessarily subject to merits preemption under Section 514(a). See, *e.g.*, *Rice v. Panchal*, 65 F.3d 637, 646 n.10 (7th Cir. 1995).

Like the Section 514(a) merits preemption question presented in *United States Healthcare Systems*, application of the doctrine of complete preemption under Section 502(a) to the myriad malpractice and negligence claims asserted against managed health care organizations has engendered confusion and an ever-increasing number of conflicting rulings in the federal courts. This Court has yet to address the complete preemption issue in this important factual context. Lacking guidance from this Court, the federal courts have employed differing analytical frameworks, reached widely divergent conclusions, and created tremendous uncertainty and confusion in a vitally important area of the law that affects the 123 million Americans who receive health care through ERISA-regulated employee benefit plans. The Third Circuit's decision thus raises a question of both doctrinal and practical importance, and the conflict in the circuits created by the Third Circuit's decision warrants the grant of certiorari.

In *United States Healthcare Systems*, the brief filed by the United States pursuant to this Court's invitation suggested that the Court's disposition of *Pegram v. Herdrich*, No. 98-1949 (to be argued Feb. 23, 2000), may have relevance to that case. The United States therefore suggested holding the petition in *United States Healthcare Systems* pending a decision in *Pegram*. By the same token, the *Pegram* decision may also have relevance to this case. Therefore, as an alternative to the grant of the petition for a writ of certiorari, the Court could hold the petition in abeyance pending a decision in *Pegram*.

I. The Decision Below Conflicts With Decisions By Numerous Other Courts Of Appeals

The complaint filed by respondents does ***not*** allege that the medical care provided to their baby while she was at Kennedy Hospital was inadequate, and does ***not*** allege that any diagnosis made or treatment provided during the baby's stay in the Hospital was improper. Instead, as recognized by the Third Circuit in its opinion, Counts One and Two of the Complaint "challenge[] U.S. Healthcare's policy of presumptively discharging newborn infants within twenty-four hours." App. 17a. Respondents allege that, under New Jersey common law, petitioner's health benefits plan should have provided coverage for some undefined longer period of time. Respondents are attacking an administrative pre-certification review policy that applied across-the-board to all plan participants,[4] and are ***not*** complaining of the specific medical treatment rendered to their baby at Kennedy Hospital. Moreover, Count Five alleges that petitioner was negligent in "adopting policies with respect to hospital utilization by its participating physicians" that discouraged physicians from re-admitting infants to the hospital. *Id.* at 50a. In addition, Count Six explicitly alleges the wrongful denial of a promised plan benefit that respondents had requested, namely an in-home visit by a pediatric nurse. *Id.* at 51a.

Each of the foregoing claims falls within the ambit of the enforcement provisions of Section 502(a)(1)(B), which entitles a plan participant "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of

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[4] As explained by the Third Circuit in *Dukes v. U.S. Healthcare*, "HMOs often contain costs through a strategy known as 'utilization review' * * *. Unlike traditional insurance policies, HMOs usually decide whether to reimburse patients for medical care prospectively — through utilization or 'pre-certification' review." 57 F.3d at 352 n.1.

the plan." In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987), this Court stated that "Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits."

In accordance with *Pilot Life*, a number of courts of appeals other than the Third Circuit have held that where, as here, the plaintiffs' claims do not arise from particular medical judgments made in the course of diagnosis or treatment, but instead are based on benefit determinations made by an HMO in its role as a plan administrator, such as pre-certification review policies, the claims are completely preempted by Section 502(a).

For instance, in *Danca v. Private Health Care Systems, Inc.*, 185 F.3d 1 (1st Cir. 1999), the First Circuit held that Section 502(a) of ERISA completely preempted medical malpractice claims arising from "allegedly negligent medical decisionmaking in the course of a precertification requirement apparently mandated by an ERISA-governed health plan." *Id.* at 2. The gravamen of the plaintiff's claims was that the defendant insurer had acted negligently in failing to precertify her admission to the hospital recommended by her physician. She alleged that the hospital to which she was admitted was inappropriate and rendered inadequate care. The First Circuit affirmed the lower court's ruling of complete preemption, reasoning as follows:

> Although we recognize that the allegedly negligent decisionmaking and consultation at issue here may be characterized as medical in nature, this fact alone does not remove the state causes of action from the scope of §502(a). Nor does the fact that the allegedly negligent conduct was not in itself a final "benefits" determination, but only part of a precertification decision, control * * *. What matters, in our view, is that the conduct was indisputably part of the process used to assess a participant's claim for a benefit

> payment under the plan. As such, any state-law-based attack on this conduct would amount to an "alternative enforcement mechanism" to ERISA's civil enforcement provisions contained in ERISA §502(a), 29 U.S.C. §1132(a), because "all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans [should] be treated as federal questions governed by § 502(a)." *Pilot Life*, 481 U.S. at 56.

185 F.3d at 5-6.

The case for complete preemption is even stronger here than in *Danca*, because the complaint here does ***not*** involve allegations of "negligent decisionmaking and consultation." Rather, as discussed above, the gravamen of the claims in this case is that petitioner was negligent in adopting a precertification review policy presumptively limiting newborns' hospital stays to twenty-four hours, and the claims do ***not*** arise out of any particular medical decisions made at Kennedy Hospital regarding respondents' child.

In a very recent decision, *Thompson v. Gencare Health Systems, Inc.*, No. 99-2433, 2000 U.S. App. LEXIS 1963 (8th Cir. Feb. 14, 2000), the Eighth Circuit also held that a medical malpractice claim arising from a precertification decision was completely preempted by Section 502(a) of ERISA. Plaintiff had brought a malpractice action in state court based on defendant's failure to pre-certify high-dose chemotherapy or bone marrow transplant procedures for his wife. The Eighth Circuit affirmed the trial court's ruling that the complaint was properly removed to federal court based on the complete preemption doctrine. The court stated that defendant's only role in the cancer treatments for plaintiff's wife "was to make pre-certification benefit decisions on behalf of the plan," and Section 502(a) "completely preempts a state law medical malpractice claim when the essence of [the] claim rests on the denial of benefits." *Id.* at *3-*4.

Another recent decision finding complete preemption of medical malpractice claims under Section 502(a) of ERISA is *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999), petition for cert. pending, No. 99-1083. In *Hull*, a plan subscriber sued the administrator of his plan for medical malpractice after the administrator denied preauthorization for a thallium stress test requested by the subscriber's treating physician. The Eighth Circuit affirmed the lower court's ruling that the plaintiff's malpractice claim was completely preempted, stating as follows:

> [A]lthough Hull's characterization of his claims sound in medical malpractice, the essence of his claim rests on the denial of benefits. As a Plan participant, he could have brought an action under section 502(a). Because his claims relate to the administration of benefits, they fall squarely within the scope of section 502(a). Therefore, Hull's claims are completely preempted by ERISA. Plan administrators necessarily exercise medical judgment in determining benefits due under the plan. To find that Hull's claims are not preempted would be to expose plan administrators to varying state causes of action for claims within the scope of section 502(a). This "would pose an obstacle to the purposes and objectives of Congress." *Pilot Life*, 481 U.S. at 52.

188 F.3d at 943.

Other appellate decisions finding complete preemption of malpractice and negligence claims against managed health care organizations analogous to those asserted here include *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1485, 1488-1490 (7th Cir. 1996) (Section 502(a) completely preempted malpractice claim arising from utilization review decision which led to plaintiff being "prematurely discharged from the hospital" without the necessary rehabilitation after knee surgery); *Cannon v. Group Health Serv., Inc.*, 77 F.3d 1270 (10th Cir.) (Section 502(a) completely preempted suit arising from denial of preauthorization for bone marrow transplant), cert. denied, 519

U.S. 816 (1996); *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993) (Section 502(a) completely preempted claims arising from plan's refusal to precertify payment for heart surgery at a hospital outside plan's service area), cert. denied, 510 U.S. 1045 (1994); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1324 (5th Cir.) (Section 502(a) completely preempted claims based on pre-certification decision that pregnant woman should receive in-home nursing care rather than hospitalization), cert. denied, 506 U.S. 1033 (1992); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (Section 502(a) completely preempted claims arising from refusal of psychiatric benefits to subscriber pursuant to utilization review); and *Parrino v. FHP, Inc.*, 146 F.3d 699 (9th Cir.) (Section 502(a) completely preempted claims stemming from delay in pre-certifying payment for proton beam therapy), cert. denied, 525 U.S. 1001 (1998).

The claims in this case are analytically indistinguishable from those found to be completely preempted by the courts of appeals in the foregoing cases. At issue here is a plan administration policy affecting ***all*** subscribers, not the particular medical treatment provided to respondents' baby. Respondents have not alleged that the medical care provided to their baby at Kennedy Hospital was deficient; rather, their claims arise from an across-the-board pre-certification review policy in which petitioner made a prospective determination of eligibility for plan benefits. Indeed, in the words of the Third Circuit, the complaint "challenges U.S. Healthcare's policy of presumptively discharging newborn infants within twenty-four hours." App. 17a.

In *Pilot Life*, this Court stated that Section 502(a) of ERISA is the "exclusive" remedial provision of ERISA and may not be "supplemented or supplanted by varying state laws." 481 U.S. at 52, 56. Similarly, in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990), this Court stated:

> It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement.

Accord *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995) ("ERISA pre-empted state laws that mandated employee benefit structures or their administration").

Here, respondents are improperly attempting to use New Jersey common law to impose liability on petitioner for failing to adopt a pre-certification review policy that would have provided coverage for longer than twenty-four hours after childbirth. This effort is "fundamentally at odds with the goal of uniformity that Congress sought to implement." *Ingersoll-Rand*, 498 U.S. at 142.[5]

This case involves a prototypical pre-certification review policy, and such policies are the hallmark of managed health care. Unlike the Third Circuit, numerous courts of appeals have held that state law attacks on such policies would amount to impermissible "alternative enforcement mechanisms" to those set forth in Section 502(a) of ERISA. *Travelers*, 514 U.S. at

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[5] Several years after the events at issue in this lawsuit, Congress amended ERISA to prohibit, with certain exceptions, a "group health plan, and a health insurance issuer offering group health insurance coverage" from restricting "benefits for any hospital length of stay in connection with childbirth for the mother or newborn child" to less than 48 hours following normal vaginal deliveries and less than 96 hours following a Cesarean section. 29 U.S.C. §1185(a)(1)(A). This ERISA amendment reflects that Congress can and does mandate employee benefit plan policies of the sort respondents sought to impose in this case through state common law. The primacy of federal law need not be compromised, as it is by the decision below, in order for appropriate policies to be set.

658. The conflict between the Third Circuit's decision and the other courts of appeals' decisions cited above is stark, and that conflict can only be resolved by this Court.

II. This Court's Review Is Needed To Bring Coherence To An Important Area Of Law That Has Caused Confusion In The Federal Courts

As petitioner previously noted in its pending petition for certiorari in *United States Healthcare Systems*, although this Court has rendered decisions in 17 cases addressing the boundaries of ERISA's preemptive reach,[6] it has not yet addressed the issues of ERISA merits preemption or complete preemption in the context of a medical malpractice or negligence-based action against an ERISA-governed health maintenance organization. This Court observed in *DeBuono* that the ERISA preemption issue has "generated an avalanche of litigation in the lower courts" (520 U.S. at 808 n.1); a significant portion of that avalanche is composed of malpractice and negligence lawsuits against health maintenance organizations. Indeed, in its February 14, 2000, decision in *Thompson v. Gencare Health Systems*, the Eighth Circuit noted that whether Section 502(a) of ERISA completely preempts such lawsuits "is a recurring legal issue." 2000 U.S. App. LEXIS 1963, at *2.

Lacking guidance from this Court, the federal courts have struggled mightily with the interplay of the civil enforcement provisions of Section 502(a) of ERISA with the myriad types of tort claims asserted against health maintenance organizations and other ERISA-governed health plans. Ascertaining the appropriate scope of ERISA preemption is crucial because ERISA affects virtually all Americans who obtain health benefits through a private employer. All health benefit plans obtained through a qualified employer are within the scope of

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[6] See *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 808 n.1 (1997); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999).

ERISA, regardless of whether the benefits are provided through a contract with an insurer, an HMO, or a self-funded plan.

In the brief it filed in *United States Healthcare Systems*, the United States stated (p. 18) as follows:

> We agree with petitioner (Pet. 19-22) that, regardless of the merits, this is an area of law of great importance. A majority of the 123 million Americans who receive health care through ERISA-regulated employee benefit plans are now subject to a managed care regime in which at least some coverage decisions are made before treatment is provided * * *. The profusion of litigation in the lower courts as to the extent of ERISA preemption with respect to activities by HMOs is further testament to the importance of the issues presented and the regularity with which they arise. And while Congress may eventually enact new legislation in this field, it has not yet done so, and the issues under current law are significant enough to warrant review by the Court.

Numerous commentators have noted that "lower courts have struggled, in vain, to find a manageable framework * * * through which they could apply ERISA preemption to claims against HMOs. The result has been a panoply of confusion among courts, HMOs, physicians, and subscribers * * *." Comment, *Healthcare: ERISA Preemption and HMO Liability — A Fresh Look at ERISA Preemption in the Context of Subscriber Claims Against HMOs*, 49 OKLA. L. REV. 677, 679 (1996). The "myriad of confusion" that now exists in the federal courts with respect to the proper application of ERISA preemption to tort claims against HMOs "has served to erode the public trust of HMOs, government, and the judicial system." *Id.* at 701.

A very recent article points out that "[w]ith no specific guidance from the Supreme Court in this area, lower courts have

floundered and strained" and "there is no consistency in the logic courts have applied, and therefore no clarification of the scope of ERISA pre-emption." R. Charrow & L. Greenlees, *ERISA Pre-emption — A Law in Search of a Doctrine*, HEALTH LAW DIGEST, March 1999, at 10. The authors conclude as follows:

> Until the Supreme Court addresses the ERISA pre-emption issue, healthcare attorneys can expect three things. First, there will be an increase in the frequency of federal appeals court decisions devoted to ERISA pre-emption issues. Second, the courts will continue to struggle by drawing distinctions — some meaningful, some not — in the hope of reaching results that are both equitable and in accord with the broad pre-emption provision. Third, the mass of appeals court decisions will be of little help; it will still be difficult for any tort litigant to predict with any degree of certainty the outcome of most ERISA pre-emption cases. It is this uncertainty that makes ERISA pre-emption a complex and tense issue in need of Supreme Court guidance.

Id. at 14. Accord K. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. ON REG. 255, 304 (1996) (analyzing the numerous cases considering ERISA preemption of tort claims against HMOs and concluding that "the outcomes on the issue of ERISA preemption have bene inconsistent — indeed, the situation might be characterized as one of utter confusion on the issue"); P. Jacobson & S. Pomfret, *Form, Function and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985, 1032 (1998) (lacking Supreme Court guidance, lower court decisions considering ERISA preemption in context of tort claims against HMOs have been marked by "instability, unpredictability, and a lack of uniformity — exactly the problem Congress intended the preemption clause to cure"); Note, *You Can't Get There From Here — Questioning the*

Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs, 30 GA. L. REV. 1023, 1051 (1996) (observing that courts have adopted divergent approaches in handling the issue of whether ERISA preempts malpractice claims against HMOs, and "these various approaches have created incongruity and analytical inconsistency among courts").

Complete preemption under ERISA in the context of malpractice and negligence claims against managed health care companies is an important and recurring issue that will continue to perplex and divide the federal courts until this Court steps in and provides much-needed guidance and clarity. This case offers an excellent opportunity to the Court to assist the federal courts in grappling with this difficult issue.

CONCLUSION

The petition for a writ of certiorari should be granted. Alternatively, the petition should be held pending this Court's decision in *Pegram v. Herdrich*, No. 98-1949, and then disposed of accordingly.

Respectfully submitted,

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FEBRUARY 2000

APPENDICES

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 98-5222, 98-5262 and 98-5263

In re: U.S. HEALTHCARE, INC.,
Petitioner in No. 98-5222

STEVEN BAUMAN, MICHELLE BAUMAN,
Individually and as Administrators ad prosequendum
of the Estate of MICHELINA BAUMAN, deceased

v.

U.S. HEALTHCARE, INC., KENNEDY MEMORIAL
HOSPITAL, Washington Township Division, KAMILA
NEMEH, M.D., JOHN DOES (1-5)

U.S. HEALTHCARE, INC.,
Appellant in No. 98-5262

STEVEN BAUMAN MICHELLE BAUMAN,
Individually and as Administrators ad prosequendum
of the Estate of MICHELINA BAUMAN, deceased,
Appellants in No. 98-5263

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v.

U.S. HEALTHCARE, INC., KENNEDY MEMORIAL
HOSPITAL, Washington Township Division, KAMILA
NEMEH, M.D., JOHN DOES (1-5)

On Appeal from the United States District Court
for the District of New Jersey

(D.C. Civ. No. 97-cv-02905)
District Judge: Hon. Stanley S. Brotman

Argued: April 6, 1999
Before: SLOVITER, ALITO and ALARCON,*
Circuit Judges
(Filed September 16, 1999)

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* Hon. Arthur L. Alarcon, Senior Circuit Judge for the United States Court of Appeals for the Ninth Circuit, sitting by designation.

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OPINION OF THE COURT

SLOVITER, *Circuit Judge*.

This case calls upon us to revisit the issue of "complete preemption" under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a), in the context of a lawsuit claiming medical malpractice, a question we last considered in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995).

The plaintiffs, Steven and Michelle Bauman, brought suit in a New Jersey state court for damages arising from the death of their newborn daughter, Michelina Bauman. The complaint names as defendants Kamflah Nemeh, M.D. (the pediatrician responsible for the treatment of Michelina); Kennedy Hospital in Washington Township, New Jersey (the hospital where Michelina was born); and The Health Maintenance Organization of New Jersey, Inc., a subsidiary of U.S. Healthcare, Inc. (collectively "the HMO") (the health maintenance organization

of which the Baumans were members). The complaint asserts direct tort claims against all three defendants and also alleges vicarious liability on the part of Kennedy Hospital and the HMO.

U.S. Healthcare, joined by the other defendants, filed a removal petition, basing federal jurisdiction on the doctrine of complete preemption under section 502 of ERISA. U.S. Healthcare then moved in the District Court for dismissal or, in the alternative, summary judgment on the ground that all of the Baumans' claims were subject to express preemption under section 514(a) of ERISA. The Baumans moved to remand, arguing that there was no federal jurisdiction over any of their claims. The District Court granted U.S. Healthcare's motion in part, concluding that federal jurisdiction exists over Count Six of the Baumans' complaint by virtue of the complete preemption doctrine. The court further concluded that Count Six was subject to express preemption under ERISA section 514(a) and it therefore dismissed that count. Having dismissed the only count for which it found there was federal jurisdiction, the District Court then declined to exercise supplemental jurisdiction over the remaining counts against U.S. Healthcare and the other defendants and remanded them to state court under 28 U.S.C. § 1367(c)(3).

U.S. Healthcare has filed both a Petition for a Writ of Mandamus and a Notice of Appeal from the District Court's order. The Baumans have cross-appealed the District Court's order dismissing Count Six and denying their motion to remand all their claims to New Jersey state court under 28 U.S.C. § 1447.

Michelle Bauman gave birth to Michelina Bauman at Kennedy Hospital in Washington Township, New Jersey, on May 16, 1995. In accordance with the health care benefits pre-certification provided by the HMO, Dr. Nemeh, an independent health care provider contracting with the HMO, discharged

mother and newborn from the hospital after twenty-four hours. On May 18, the day after Michelina was discharged and two days after she was born, the Baumans noticed that Michelina was ill. They made numerous telephone calls to Doctor Nemeh, but she did not advise them to bring Michelina back to the hospital. They also contacted U.S. Healthcare and requested an in-home visit by a pediatric nurse, but no such nurse was provided. Michelina contracted a Group B strep infection that was undiagnosed and untreated. It developed into meningitis and she died that same day.

The Baumans' complaint was filed in New Jersey Superior Court, Camden County, in May 1997. We address only the four counts against U.S. Healthcare.[1] In Count One, the Baumans allege that the U.S. Healthcare policy "encouraged, pressured, and/or directly or indirectly required" the twenty-four hour pre-certified discharge used by the doctor and hospital. App. at 16. In implementing this policy, the complaint continues, U.S. Healthcare acted "without adequate consideration" for the policy's medical appropriateness and "without due care for the health and safety" of members and their children. App. at 16. Count One also includes a claim for vicarious liability against U.S. Healthcare for the negligence of its alleged agents Nemeh and Kennedy Hospital in prematurely discharging the newborn after only twenty-four hours while the infection went undiagnosed.

Count Two alleges that Michelina did not receive timely diagnosis and treatment of the deadly infection. The count states that U.S. Healthcare's adoption of the twenty-four-hour pre-certified discharge policy, despite U.S. Healthcare's knowledge that newborns were at risk for developing diseases and that the policy would delay diagnosis and treatment,

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[1] Neither Nemeh nor Kennedy Hospital is a party to the appeal or the petition for writ of mandamus.

manifested reckless indifference to the "health consequences of its policy" and was "motivated only by the financial profit" realizable from having to pay for only a single day in hospital. App. at 17.

The Baumans allege in Count Five that U.S. Healthcare negligently adopted "policies with respect to hospital utilization" that discouraged participating physicians from "re-admitting infants to the hospital when health problems" arose after discharge. App. at 20. They also allege that U.S. Healthcare negligently "fail[ed] to exercise due care in the selection, supervision, training, and/or monitoring" of Dr. Nemeh. App. at 20. This count includes both a direct negligence claim and a vicarious liability claim for the failure to diagnose and treat Michelin's infection.

Count Six alleges that in light of the discharge, Michelina's "medically appropriate care" required an in-home visit by a pediatric nurse to "ensure [her] health and well-being." App. at 21. The Baumans requested such a visit in their May 18 phone call and, according to the complaint, the plan's L'il Appleseed Program assured such visits, which U.S. Healthcare negligently failed to provide in this instance. This count also included negligence claims against the hospital and doctor for their failure to report Michelina's birth to the HMO, which would have supported the request for a pediatric nurse.

On June 12, 1997 U.S. Healthcare removed the action to the District Court for the District of New Jersey on the ground that section 502(a) of ERISA provides federal jurisdiction over the complaint by virtue of the "complete preemption" doctrine. A month later, the Baumans moved to remand the case to state court. While the case was in the District Court, U.S. Healthcare requested dismissal of all four counts or claims against it on the basis of section 514(a) express preemption under ERISA.

The District Court remanded Counts One, Two and Five, but did so pursuant to 28 U.S.C. § 1367(c)(3) rather than under

28 U.S.C. § 1447(c) as the Baumans requested. The court denied the motion to remand Count Six and, as to that count, granted U.S. Healthcare's motion to dismiss.

In its opinion dated March 30, 1998, the District Court explained these rulings as follows: The court held that removal was proper because Count Six states a claim that fits within the scope of section 502(a) of ERISA (covering claims "to recover benefits due" under the terms of the plan), and that therefore it had subject matter jurisdiction under the doctrine of "complete preemption." It held, concomitantly, that Count Six was expressly preempted under section 514(a) of ERISA and should be dismissed. *See Bauman v. U.S. Healthcare, Inc.*, 1 F. Supp. 2d 420, 425 (D.N.J. 1998). However, the District Court held that the other three counts pled against U.S. Healthcare were not completely preempted. *Id.* at 423-24. It then exercised its discretion and remanded those claims to state court under 28 U.S.C. § 1367(c)(3), reasoning that the case was relatively early in its proceedings and the single dismissed claim providing subject matter jurisdiction was relatively minor among all the claims asserted against U.S. Healthcare. *Id.* at 426.

On April 1, the District Court amended its original order to state that it dismissed Count Six with respect to U.S. Healthcare only. The remand of the other counts was not changed.

U.S. Healthcare filed a timely notice of appeal as well as a separate petition for a writ of mandamus. The Baumans cross-appealed the court's dismissal of Count Six and denial of their motion to remand under 28 U.S.C. § 1447(c). This court referred the petition for a writ of mandamus to a merits panel and directed a consolidated briefing schedule for the appeal, cross-appeal, and petition. Additionally, we granted the motion of the Secretary of Labor to file a brief as *amicus curiae* in support of the Baumans.

II.

We must first consider our jurisdiction to hear this case. *See Collinsgru v. Palrnyra Bd. of Educ.*, 161 F.3d 225, 228-29 (3d Cir. 1998). The District Court held that there was federal subject matter jurisdiction pursuant to 28 U.S.C. § 1331 after removal, based on its ruling that Count Six was completely preempted under ERISA; it also ruled that it therefore had supplemental jurisdiction under 28 U.S.C. § 1367(a) over the remaining state law counts. Before we consider the District Court's subject matter jurisdiction, we must decide whether we have appellate jurisdiction. This, in turn, depends on whether the District Court's amended order dismissing Count Six and remanding the case to state court is a final decision, or, if not, whether we should exercise mandamus jurisdiction.

A.

In the original order dated March 31, 1998, the District Court stated, *inter alia,* that "U.S. Healthcare's Motion to Dismiss or, in the Alternative, for Summary Judgment is granted in part, and Count Six of Plaintiffs Complaint is dismissed." App. at 171. The court proceeded to remand Counts One through Five, Seven, and Eight to the state court. In the order amended on April 1, the District Court modified only the dismissal of Count Six, stating that "Plaintiff's Complaint is dismissed as to U.S. Healthcare only." *Bauman*, 1 F. Supp. 2d at 426 (the "Amended Order").[2]

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[2] Although the Amended Order failed to dispose expressly of Count Six as it applied to the hospital and doctor, counsel for both U.S. Healthcare and the Baumans agreed at oral argument that the District Court intended to remand all of the remaining claims, and that its failure to do so was merely a clerical or technical oversight. Federal Rule of Civil Procedure 60(a) provides that clerical or technical errors may be corrected at any time, even after an appeal has been filed. *See In re West Tex. Marketing Corp.*, 12 F.3d 497, 504 (5th Cir. 1994).

However, the District Court's opinion expressly set forth its intention to dispose of the entire case. *See id.* ("[T]his Court finds that it is proper to remand *the remainder of this action* to state court." (emphasis added)). In the conclusion of its opinion, the court stated "[T]his Court will enter an appropriate order remanding the remainder of the case" to the New Jersey state court. *Id.* (emphasis added). In *Ford Motor Co. v. Summit Motor Products, Inc.*, 930 F.2d 277, 286 (3d Cir. 1991), we stated, "Should there be 'any ambiguity or obscurity or if the judgment fails to express the rulings in the case with clarity or accuracy, reference may be had to the findings and the entire record for the purpose of determining what was decided.'" (quoting *Security Mutual Casualty Co. v. Century Casualty Co.*, 621 F.2d 1062, 1066 (10th Cir. 1980)).

We, therefore, conclude that the District Court intended to remand the claims against Kennedy Hospital and Dr. Nemeh in Count Six to the state court but, through a clerical error, overlooked amending the final paragraph of its order to reflect this disposition. In light of our precedent, *see* note 2 *supra*, we treat the order as one that remanded all non-dismissed claims, and one that is accordingly final. Consequently, we turn now to the nature of our jurisdiction.

Remand for this purpose is not always necessary. *See* 11 Charles Alan Wright, Arthur P. Miller & May Kay Kane, *Federal Practice and Procedure: Civil 2d* § 2856, at 251-52 (2d ed. 1995) (Notwithstanding the availability of Rule 60(a)'s mechanism for obtaining a correction from the district court, appellate courts "have treated clerical errors, oversights, and omissions as if they had been corrected and have not required the formality of a correction by the district court."). For example, in a case in which the jury rendered verdicts on both causes of action sued upon, but the district court entered only one judgment, this court deemed the failure of the district court to enter two judgments an "obvious clerical error" and treated the appeal as if two judgments had been entered without requiring the parties to return to "a presently very much overburdened United States District Court for technical correction." *Brown v. Moore*, 247 F.2d 711, 714 n.2 (3d Cir. 1957).

B.

Following the District Court's holdings that there was subject matter jurisdiction over Count Six under 28 U.S.C. § 1331 and supplemental jurisdiction over the remaining claims, the court invoked its discretionary authority to decline to retain supplemental jurisdiction and remanded the non-dismissed counts and claims under 28 U.S.C. § 1367(c)(3), rather than under 28 U.S.C. § 1447(c), which governs remand when subject matter jurisdiction is wholly lacking. Had it used the latter statute we would have no appellate jurisdiction, as that section precludes review of a district court's remand except in limited circumstances not applicable here. *See* 28 U.S.C. § 1447(d) ("an order remanding a case to the State court from which it was removed is not reviewable on appeal or otherwise. . ."). Although § 1367 does not contain a similar bar to appellate jurisdiction following a discretionary remand, the Baumans contend the remand order cannot be reviewed because it is not final under 28 U.S.C. § 1291. Indeed, the order that U.S. Healthcare appeals from — an order partially denying a motion to dismiss — is interlocutory in nature and not ordinarily appealable under § 1291. *See, e.g., Akerly v. Red Barn Sys., Inc.*, 551 F.2d 539, 543 (3d Cir. 1977).

U.S. Healthcare counters with substantial authority from this court to support reviewability. It cites *Hudson United Bank v. LiTenda Mortg. Corp.*, 142 F.3d 151, 155 (3d Cir. 1998), as approving appellate jurisdiction of a district court's order dismissing the federal counts and then exercising its discretionary power under 28 U.S.C. § 1367(c)(3) to remand the remaining claims. It also cites *Carr v. American Red Cross*, 17 F.3d 671 (3d Cir. 1994), where we accepted appellate jurisdiction under the collateral order doctrine after the district court dismissed a party and then, using its discretion, remanded the case.

We find most apt and controlling our decision in *Pennsylvania Nurses Ass'n v. Pennsylvania State Educ. Ass'n*, 90 F.3d 797 (3d Cir. 1996). In that case, two labor organizations were competing for the right to represent nurses in several health care facilities. The Nurses Association filed eleven state tort law claims against its rival, the Education Association. The district court held that nine claims were preempted by federal labor law and granted judgment on the pleadings as to those counts, but it held that two were not preempted and remanded them to the state court. The Nurses Association appealed, and the Education Association cross-appealed.

We held that we had appellate jurisdiction under § 1291 because a discretionary remand under §1367(c)(3) divests a federal court of "all control over the action." 90 F.3d at 801; *accord Engelhardt v. Paul Revere Life Ins. Co.*, 139 F.3d 1346, 1350 (11th Cir. 1998) (accepting appellate jurisdiction after § 1367(c)(3) remand to review district court's discretionary order). This is consistent with our reasoning in *Carr*, where we noted that appellate review of a discretionary remand under § 1367(c)(3) is appropriate because the practical effect of rejecting jurisdiction would have been to render a party unable to obtain later review of that decision. *See Carr,* 17 F.3d at 678.

We have essentially the same circumstance here: preemption of a state-law claim and remand of the remaining claims to state court. Following *Pennsylvania Nurses Association*, we conclude that jurisdiction lies under § 1291. As a result, U.S. Healthcare's petition for a writ of mandamus is moot. *See Pennsylvania Nurses Ass'n*, 90 F.3d at 801. Jurisdiction over the Baumans' cross-appeal from the dismissal of Count Six raises no issue as it is clearly final under § 1291.

III.

Turning to the merits of the parties' contentions, we review the District Court's decision to remand under §1367(c)(3) for

abuse of discretion; however, to the extent that the underlying issue giving rise to that remand decision, in this case the extent of preemption, is one of law, our review is *de novo*. *See Engelhardt*, 139 F.3d at 1351 n.4; *Zuniga v. Blue Cross & Blue Shield of Mich.*, 52 F.3d 1395, 1400 (6th Cir. 1995). U.S. Healthcare argues that the District Court erred when it concluded that ERISA does not completely preempt Counts One, Two and Five of the Baumans' complaint. The Baumans argue that the court erred when it ruled Count Six was completely preempted.

A.

Under the "well-pleaded complaint" rule, federal jurisdiction is lacking unless a federal question appears on the face of a properly pleaded complaint; a federal defense does not confer subject matter jurisdiction. *See Franchise Tax Bd. of Cal. v. Construction Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 9-12 (1983); *Louisville & Nashville R.R. Co. v. Mottley*, 211 U.S. 149, 152 (1908). There is nothing on the face of the Baumans' complaint that reveals any federal cause of action, and it is manifest that they have not, through "artful pleading," sought to defeat jurisdiction that would otherwise be apparent on the face of the complaint. *See Parrino v. FHP, Inc.*, 146 F.3d 699, 704 (9th Cir. 1998). Hence, according to the usual operation of the well-pleaded complaint rule, federal jurisdiction would be lacking where, as here, the complaint is based entirely on state law.

U.S. Healthcare seeks to fall within the narrow exception to the well-pleaded complaint rule for instances where Congress has expressed its intent to "completely pre-empt" a particular area of law such that any claim that falls within this area is "necessarily federal in character." *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987). Unlike ordinary preemption, which would only arise as a federal defense to a state-law claim, complete preemption operates to confer original federal subject

matter jurisdiction notwithstanding the absence of a federal cause of action on the face of the complaint. The Supreme Court has held that in enacting the civil-enforcement provisions of section 502(a) of ERISA, Congress intended to completely preempt state law. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987).

As Professor Wright has noted, "preemption" is used in the law in more than one sense. Charles Alan Wright, Law of Federal Courts § 238 at 230. It is important to distinguish complete preemption under section 502(a) of ERISA, which is used in this sense as a jurisdictional concept, from express preemption under section 514(a) of ERISA, which is a substantive concept governing the applicable law. *See Joyce v. RJR Nabisco Holdings Corp.*, 126 F.3d 166, 171-72 (3d Cir. 1997). There are instances in which the Supreme Court has implied a congressional intent to preempt state law, *see, e.g., International Paper Co. v. Ovellette*, 479 U.S. 481, 491-92 (1987), but it included an express preemption provision in ERISA. Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." 29 U.S.C. § 1144(a). State-law claims that are subject to express preemption are displaced and thus subject to dismissal. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). Claims that are completely preempted are "necessarily federal in character," and thus are converted into federal claims. *See Taylor*, 481 U.S. at 63.

Consequently, to determine whether any of the claims stated in the Baumans' complaint are completely preempted, we consider whether they "fall within the scope of" ERISA's civil-enforcement provisions. *Dukes*, 57 F.3d at 355. U.S. Healthcare argues that the complaint essentially seeks recovery under state law for the HMO's denial of benefits under a health-benefits plan governed by ERISA. It continues, because section 502(a)(1)(B) creates a cause of action to recover such benefits,

all of the Baumans' claims, including those asserted in Counts One, Two and Five, come within that section and are therefore completely preempted. Under section 502(a)(1)(B), a participant or beneficiary may bring an action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

We last considered the operation of this provision in the context of medical malpractice actions in *Dukes*, where we reviewed the complaints filed in two consolidated cases. In one of these cases, the widow of Darryl Dukes, who had been a participant in a U.S. Healthcare HMO, filed an action in state court alleging medical malpractice and negligence against numerous defendants based on the failure of the doctors to perform a blood test that would have revealed the patient's high blood sugar levels. The complaint also alleged that the HMO was both vicariously liable and directly negligent in failing to use reasonable care in, *inter alia*, screening, evaluating, and monitoring the providers of the medical services dispensed to beneficiaries. *See Dukes*, 57 F.3d at 352. In the second case, the plaintiffs alleged that the obstetrician who treated the expectant mother negligently ignored symptoms of preeclampsia, and that this negligence resulted in a stillbirth. The plaintiffs also sued the HMO on theories of ostensible and actual agency as well as for negligence in its "selection, employment, and oversight of the medical personnel who performed the actual medical treatment." *Id.* at 353.

We rejected U.S. Healthcare's complete preemption arguments in both cases. Analyzing the gravamen of the complaints, we observed that neither one pled state claims falling within the scope of ERISA's civil enforcement scheme because there was nothing raised regarding a failure "to provide benefits due under the plan." The plaintiffs did not allege that the failure to perform the tests arose in any way from a denial of

benefits under the ERISA plan involved. *See id.* at 356-57. Rather, both complaints asserted claims regarding the quality of the care received. *See id.* at 357. We emphasized that the statutory language permitting an ERISA action to "'recover benefits due . . . under the terms of [the] plan' is concerned exclusively with whether or not the benefits due under the plan were actually provided. The statute simply says nothing about the quality of benefits received." *Id.* Nor could we find any basis in the legislative history for concluding that quality claims, as opposed to quantity ones, would be completely preempted. *See id.*

Similarly, we rejected U.S. Healthcare's arguments that the complaints at issue raised claims regarding "rights under the terms of the plan;" we held that the phrase applied to such matters as benefit eligibility procedures, as opposed to a specific benefit under the plan. *See id.* Moreover, the negligence counts alleged claims under pre-existing state law rather than "new 'rights under the terms of the plan.'" *Id.* at 358. We observed that "patients enjoy the right to be free from medical malpractice regardless of whether . . . care is provided through an ERISA plan." *Id.*

Perhaps the most significant contribution made by the *Dukes* opinion was the distinction drawn between (1) state law claims directed to the quality of benefits provided, which are not completely preempted, and (2) claims "that the plans erroneously withheld benefits due" or that seek "to enforce [plaintiffs'] rights under their respective plans or to clarify their rights to future benefits," which are subject to complete preemption. *Id.* at 356. To reiterate, we embraced a distinction between claims pertaining to the quality of the medical benefits provided to a plan participant and claims that the plan participant was entitled to, but did not receive, a certain quantum of benefits under his or her plan. *See id.* at 357-58.

There are some cases in which it may be difficult to distinguish between claims challenging the quality of benefits rather than their quantity. *See id.* ("We recognize that the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear . . ."). These difficulties arise, at least in part, because the same HMO may have assumed both the role as a plan administrator and the separate role as a provider of medical services.

As an administrator overseeing an ERISA plan, an HMO will have administrative responsibilities over the elements of the plan, including determining eligibility for benefits, calculating those benefits, disbursing them to the participant, monitoring available funds, and keeping records. As we held in *Dukes*, claims that fall within the essence of the administrator's activities in this regard fall within section 502(a)(1)(B) and are completely preempted.

In contrast, as noted by the Secretary, when the HMO acts under the ERISA plan as a healthcare provider, it arranges and provides medical treatment directly or through contracts with hospitals, doctors, or nurses. *See Dukes*, 57 F.3d at 361; *see also Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1329-34 (5th Cir. 1992) (recognizing that HMOs act as both health care providers and plan administrators). In performing these activities, the HMO is not acting in its capacity as a plan administrator but as a provider of health care, subject to the prevailing state standard of care. For obvious reasons, U.S. Healthcare contends that all of the Baumans' claims against it fall into the administrative category, which are completely preempted, and that therefore the remand of the three counts to state court was erroneous.

In examining the language of Counts One, Two, and Five, we conclude that the District Court did not err in holding that these counts were not completely preempted. It is significant that none of these three counts as pled alleges a failure to

provide or authorize benefits under the plan, and the Baumans do not claim anywhere in these counts that they were denied any of the benefits that were due under the plan.

Count One challenges U.S. Healthcare's policy of presumptively discharging newborn infants within twenty-four hours. This count alleges that the HMO adopted and implemented this policy "without adequate consideration for whether this policy was medically appropriate." App. at 16. The count charges U.S. Healthcare with both direct negligence for the adoption and implementation of the policy and with vicarious liability for the negligence of Dr. Nemeh and Kennedy Hospital.

We have already held in *Dukes* that a vicarious liability claim against U.S. Healthcare for a doctor's malpractice does not fall within the scope of section 502(a)(1)(B). In this case, the vicarious liability claim arising from Michelina's premature discharge, as stated in Count One, is indistinguishable in any meaningful way from those that we held were not completely preempted in *Dukes*.

With respect to the direct negligence claim, the Baumans' challenge to U.S. Healthcare's twenty-four-hour discharge policy is directed at the HMO's actions in what we characterized in *Dukes* as an HMO's role in "arranging for medical treatment" rather than its role as a plan administrator determining what benefits are appropriate. *Dukes*, 57 F.3d at 360. Thus, it is the HMO's essentially medical determination of the appropriate level of care that the Baumans claim contributed to the death of their daughter. This is not a claim that a certain benefit was requested and denied. As the Secretary points out, under the facts as pleaded in the complaint, U.S. Healthcare's policy and incentive structure were such that "the Baumans never had the option of making an informed decision as to whether to pay for the hospitalization themselves," as would occur in a situation in which coverage is sought and denied. Secretary of Labor Br. at

19. Accordingly, this claim fits squarely within the class of claims that we identified in *Dukes* as involving the quality of care. Here, as in *Dukes*, "the plaintiffs . . . are attempting to hold the HMO[] liable for [its] role as the arranger[] of their [decedent's] medical treatment." *Dukes*, 57 F.3d at 361.

Count Two challenges the same actions by the HMO. It differs from Count One principally in that it charges reckless indifference on the part of U.S. Healthcare. This count charges that U.S. Healthcare adopted its twenty-four hour presumptive discharge policy "knowing . . . that many infants would be put at risk for life-threatening disease after leaving the hospital" and that the HMO thus acted with reckless indifference to the health consequences of this policy. App. at 17. Like the negligence claim based upon the discharge policy, this count goes to the quality of care that Michelina received rather than an administrative decision as to whether certain benefits were covered by the plan.

We reject U.S. Healthcare's characterization of these counts as "quintessential" challenges to the quantity of benefits due under an ERISA plan. The allegations in Counts One and Two do not raise the failure of U.S. Healthcare to pay for a benefit or process a claim for benefits as the basis for the injury suffered. The counts are phrased in terms of the quality of the medical care provided.

In a similar vein, Count Five charges that U.S. Healthcare was "negligent in adopting hospital utilization policies . . . that discouraged . . . physicians from readmitting infants to the hospital when health problems were identified subsequent to [their] discharge from the hospital." App. at 20. Additionally, Count Five alleges that U.S. Healthcare was negligent in its "selection, supervision, training, and/or monitoring of Dr. Nemeh." *Id.*

Both aspects of this count also pertain to U.S. Healthcare's actions in its role as a provider or arranger of medical services.

As the Baumans allege, the HMO adopted policies that "encouraged, pressured, and/or directly or indirectly required" their participating physicians to discharge newborn infants and that also discouraged physicians to readmit newborn infants when the appropriate standard of care required otherwise under state law. App. at 16, 20. Assuming these allegations are true, as we must when considering a motion to dismiss, the Baumans seek recovery for decisions that U.S. Healthcare made in providing and arranging medical services, decisions that adversely influenced the medical judgment of its participating physicians.

Similarly, the portion of Count Five that alleges negligence in the HMO's selection, supervision, training, and/or oversight of Dr. Nemeh addresses not plan administration decisions, but rather decisions that the HMO allegedly made in the course of arranging for the provision of medical services. This claim is indistinguishable from the Viscontis' claim in *Dukes* that the HMO was "negligent in its selection, employment, and oversight of the medical personnel who performed the actual medical treatment," which we held was not subject to complete preemption. *Dukes*, 57 F.3d at 353, 358-59. Such claims do not involve an attempt to recover benefits due, enforce rights, or clarify future benefits under a plan, but rather seek recovery under "the quality standard found in the otherwise applicable [state] law." *Id.* at 359.

U.S. Healthcare emphasizes that the language in this count refers to its adoption of policies "with respect to hospital *utilization* by its participating physicians," and it argues that *Dukes* compels the conclusion that all claims regarding "utilization" are necessarily about "refus[al] to provide the services to which membership entitled" beneficiaries, an administrative rather than health-provider function. U.S. Healthcare Reply Br. at 20-21. A fair reading of Count Five shows that it is not directed at the "utilization review" process referred to in *Dukes*. The "utilization review" to which *Dukes*

was referring is "a cost-containment service," which entails prospective and concurrent assessments of the appropriateness of medical and hospital care. *See, e.g., Corcoran,* 965 F.2d at 1323, 1327. Utilization review in that sense is unrelated to the claim in Count Five that raises the quality-of-care consequences of the pre-certification policy, as well as U.S. Healthcare's negligent oversight of its doctors when it acted as a medical provider. Indeed, U.S. Healthcare's statement at oral argument that the twenty-four hour pre-certification policy is not a hard and fast rule and can be extended as the doctor sees fit only reinforces the view that it is a discretionary medical decision rather than an administrative one.

In summary, we conclude that the District Court did not err in holding that Counts One, Two, and Five were not claims "to recover benefits due . . . under the terms of [the] plan, falling within section 502," and hence were not completely preempted.

B.

In their cross-appeal, the Baumans contend that the District Court erred in concluding that Count Six was completely preempted. Here, as above, we look to the nature of the claims as reflected by the language of the count. The District Court read the language of Count Six, alleging U.S. Healthcare's negligence in "not providing for [an in-home] visit by a participating provider [a pediatric nurse], despite assurances under its L'il Appleseed program that such a visit would be provided and despite a telephone call . . . from the Baumans requesting this service," as stating a claim that fits under section 502(a). Therefore, the court held that it was completely preempted, and subsequently dismissed. We cannot say that the District Court was unreasonable in so holding.

On the other hand, the Baumans urge this court to interpret the complaint as a state cause of action for violating a tort duty "to provide [the Bauman family] adequate medical care, rather than a violation of a [contractual] promise . . . made to them in

their ERISA plan." Bauman Br, at 34. The Secretary concurs with the Baumans' position. Although the question as to Count Six is a close one, we agree with the Baumans and the Secretary that Count Six raises a claim regarding the adequacy of the care that Michelina Bauman received and is therefore directed toward the HMO's action in its capacity as a medical provider, rather than as a benefits administrator. As is the case in the earlier counts, Count Six raises an issue regarding the inadequacy of the quality of care provided under the plan. The mere fact that the Baumans referred in their complaint to a benefit promised by their health care plan does not automatically convert their state-law negligence claim into a claim for benefits under section 502. If, as the Baumans contend, U.S. Healthcare failed to meet the standard of care required of health care providers by failing to arrange for a pediatric nurse in a timely manner, Count Six sets forth an ordinary state-law tort claim for medical malpractice.

We recognize that we observed in *Dukes* that in some cases the quality of care may be "so low that the treatment received simply will not qualify as health care at all. In such a case, it well may be appropriate to conclude that the plan participant or beneficiary has been denied benefits due under the plan." *Dukes*, 57 F.3d at 358. This was plain dictum in *Dukes*, as there were no facts suggesting such patently low treatment. As dictum, it does not bind this panel. *See McGurt v. Trucking Employees of North Jersey Welfare Fund, Inc.*, 124 F.3d 471, 484 (3d Cir. 1997). We note in passing that U.S. Healthcare has not suggested that its failure to provide the pediatric nurse was such grossly inadequate health care as to fall within the dictum, and so we have no occasion to comment on when it would be applicable, if at all.

After it concluded that it had subject matter jurisdiction over Count Six, the District Court dismissed that count as expressly preempted by section 514(a), 29 U.S.C. § 1144(a), on the force of its determination that the count was completely preempted. Inasmuch as we conclude that Count Six was not

completely preempted, the District Court did not have subject matter jurisdiction over the complaint and should have remanded it to state court under 28 U.S.C. § 1447(c).[3] As we stated in *Dukes*, "[w]hen the doctrine of complete preemption does not apply, but the plaintiffs state claim is arguably preempted under § 514(a), the district court, being without removal jurisdiction, cannot resolve the dispute regarding preemption." *Dukes*, 57 F.3d at 355.

IV.

We will affirm the District Court's decision that Counts One, Two, and Five are not completely preempted, and we will reverse its decision that Count Six is completely preempted and reverse its order dismissing Count Six. We will therefore remand to the District Court with instructions to remand Count Six to the New Jersey state court from which it was removed. It is that court that will be in a position to decide the express preemption issue, should U.S. Healthcare raise it there.

A True Copy:
Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

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[3] As a result of our disposition, we need not reach U.S. Healthcare's contention that the District Court itself should have decided whether the claims were expressly preempted under section 514 of ERISA, rather than remanding that issue to the state court.

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 98-5222, 98-5262 and 98-5263

In re: U.S. HEALTHCARE, INC.,
Petitioner in No. 98-5222

STEVEN BAUMAN, MICHELLE BAUMAN,
Individually and as Administrators ad prosequendum
of the Estate of MICHELINA BAUMAN, deceased

v.

U.S. HEALTHCARE, INC.,
KENNEDY MEMORIAL HOSPITAL,
Washington Township Division,
KAMILA NEMEH, M.D., JOHN DOES (1-5)

U.S. HEALTHCARE INC.,,
Appellant in No. 98-5262

STEVEN BAUMAN, MICHELLE BAUMAN,
Individually and as Administrators ad prosequendum
of the Estate of MICHELINA BAUMAN, deceased,
Appellants in No. 98-5263

v.

U.S. HEALTHCARE INC.,
KENNEDY MEMORIAL HOSPITAL,
Washington Township Division,
KAMELA NEMEH, M.D., JOHN DOES (1-5)

On Appeal from the United States District Court
for the District of New Jersey
(D.C. Civ. No. 97-cv-02905)
District Judge: Hon. Stanley S. Brotman

Present: Sloviter, Alito, and Alarcon,* *Circuit Judges*

JUDGMENT

These causes came on to be heard on the record from the United States District Court for the District of New Jersey and were argued by counsel on April 6, 1999.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgment of the said District Court entered April 2, 1998, be, and the same is hereby is affirmed as to the District Court's decision that Counts One, Two, and Five are not completely preempted, and reversed as to its determination that Count Six is completely preempted. The order dismissing Count Six is reversed. The cause is remanded to the District Court with instructions to remand Count Six to the New Jersey state court from which it was removed. It is that court that will be in a position to decide the express preemption issue, should U.S. Healthcare raise it there. All of the above in accordance with the opinion of this Court.

ATTEST:

/s/_____
Clerk
Dated: September 16, 1999

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* Honorable Arthur L. Alarcon, Senior Circuit Judge for the United States Court of Appeals for the Ninth Circuit, sitting by designation.

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 98-5222, 98-5262 and 98-5263

In re: U.S. HEALTHCARE, INC.,
Petitioner in No. 98-5222

STEVEN BAUMAN, MICHELLE BAUMAN,
Individually and as Administrators ad prosequendum
of the Estate of MICHELINA BAUMAN, deceased

v.

U.S. HEALTHCARE, INC.,
KENNEDY MEMORIAL HOSPITAL,
Washington Township Division,
KAMILA NEMEH, M.D., JOHN DOES (1-5)

U.S. HEALTHCARE INC.,
Appellant in No. 98-5262

STEVEN BAUMAN, MICHELLE BAUMAN,
Individually and as Administrators ad prosequendum
of the Estate of MICHELINA BAUMAN, deceased,
Appellants in No. 98-5263

v.

U.S. HEALTHCARE INC.,
KENNEDY MEMORIAL HOSPITAL,
Washington Township Division,
KAMILA NEMEH, M.D., JOHN DOES (1-5)

On Appeal from the United States District Court
For the District of New Jersey
(D. C. Civ. No.97-cv-02905)

District Judge: Hon. Stanley S. Brotman

Present: Sloviter, Alito, and Alarcon,* Circuit Judges

AMENDED JUDGMENT

These causes came on to be heard on the record from the United States District Court for the District of New Jersey and were argued by counsel on April 6, 1999.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgment of the said District Court entered April 2, 1998, be, and the same is hereby affirmed as to the District Court's decision that Counts One, Two, and Five are not completely preempted, and reversed as to its determination that Count Six is completely preempted. The order dismissing Count Six is reversed. The cause is remanded to the District Court with instructions to remand Count Six to the New Jersey State Court from which it was removed. It is that court that will be in a position to decide the express preemption issue, should U.S. Healthcare raise it there. Costs taxed against Petitioner/ Appellant/Cross-Appellee, U.S. Healthcare. All of the above in accordance with the opinion of this Court.

ATTEST:
/s/_____
Clerk

Dated: November 17, 1999

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* Honorable Arthur L. Alarcon, Senior Circuit Judge for the United States Court of Appeals for the Ninth Circuit, sitting by designation.

Certified as a true copy and issued in lieu
of a formal mandate on December 9, 1999.

Teste:

/s/

Clerk, U.S. Court of Appeals
For the Third Circuit.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

FOR PUBLICATION
ORIGINAL FILED MAR 31 1998
WILLIAM T. WALSH, CLERK

STEVEN BAUMAN and MICHELLE BAUMAN, Individually and as Administrators ad prosequendum of the Estate of MICHELINA BAUMAN, Deceased	:	
Plaintiffs,	:	Civil Action No.97-2905
v.	:	
U.S. HEALTHCARE, INC., KENNEDY MEMORIAL HOSPITAL, Washington Township Division, KAMILA NEMEH, M.D., and JOHN DOE(S) (1-5) .	:	**OPINION**
Defendants.	:	

APPEARANCES:
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BROTMAN, J.

This is a medical malpractice case against a physician, a hospital, and a healthcare insurance provider. Plaintiffs Steven and Michelle Bauman ("Plaintiffs") filed the above- captioned negligence action in the Superior Court of New Jersey, Law Division, Camden County. Defendant U.S. Healthcare, Inc. ("U.S. Healthcare") removed the action to this Court, asserting federal jurisdiction based on Section 502(a)(1)(B) of the Employment Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(1)(B) ("Section 502(a)").

Presently before this Court is defendant U.S. Healthcare's Motion to Dismiss or, in the Alternative, for Summary Judgment. Plaintiffs counter with a Motion for Remand to New Jersey State Court in which they challenge the applicability of Section 502(a) to the present action and contend that removal was inappropriate. Plaintiffs also seek reimbursement of attorney's fees associated with their motion pursuant to 28 U.S.C. § 1447(c).

I. BACKGROUND

Michelina Bauman ("Michelina") was born on May 16, 1995. She and her mother were discharged from the hospital twenty-four hours later. Michelina died on May 18, 1995, the day following her discharge. Plaintiffs contend that she died from a virulent infection that went undiagnosed and developed into meningitis.

Defendant Kennedy Hospital is the health care facility at which she was born. Defendant Kamilah Nemeh, M.D. ("Dr. Nemeh") was the discharging physician at Kennedy Hospital. Defendant U.S. Healthcare is a Pennsylvania corporation which wholly owns a subsidiary corporation known as The Health Maintenance Organization of New Jersey, Inc. ("HMO-NJ"). HMO-NJ is a health maintenance organization that furnishes employee health care benefit benefits to plan participants,

including Plaintiffs, pursuant to employee benefit plans established under ERISA.

On May 12, 1997, Plaintiffs filed its Complaint. The counts involving U.S. Healthcare can be summarized as follows:

> Count One alleges that U.S. Healthcare acted negligently in adopting a policy that "encouraged, pressured, and/or directly or indirectly required that its participating physicians discharge newborn infants and their mothers from the hospital within 24 hours of the infant's birth."
>
> Count One also alleges that U.S. Healthcare is vicariously liable for the negligent actions of its agents Dr. Nemeh and Kennedy Hospital in discharging Michelina Bauman from the hospital after only 24 hours.
>
> Count Two alleges that U.S. Healthcare acted recklessly indifferent to the health consequences of its policy "governing discharge of mothers and newborns from the hospital within 24 hours of birth knowing, among other things, that many infants would be at risk for developing life-threatening disease after leaving the hospital and that these guidelines would result in life-threatening delays in the diagnosis and treatment of these diseases."
>
> Count Five alleges that U.S. Healthcare acted negligently in (1) "adopting policies with respect to hospital utilization by its participating physicians that discouraged these physicians from re-admitting infants to the hospital when health problems were identified subsequent to the newborns original discharge from the hospital" and in (2) "failing to exercise due care in the selection, supervision, training, and/or monitoring of Dr. Nemeh as a participating provider of health services."
>
> Count Six alleges that U.S. Healthcare acted negligently in "not providing for [an in-home] visit by a participating provider despite assurances under its L'il Appleseed

Program that such a visit would be provided and despite a telephone call . . . from the Baumans requesting this service."[1]

On June 12, 1997, U.S. Healthcare removed this case to federal court. It then moved to dismiss the Complaint pursuant to Section 514(a) of ERISA, 29 U.S.C. § 1144(a), or, in the alternative, for summary judgment. Plaintiffs have responded by moving to remand this action to state court for lack of subject matter jurisdiction pursuant to 28 U.S.C. § 1447(c) (Supp. 1996).

II. DISCUSSION

A. PLAINTIFFS' MOTION TO REMAND

Defendants removed this action on the grounds that Section 502(a) and the "complete preemption" exception to the "well-pleaded complaint rule" provided this Court with subject matter jurisdiction. Plaintiffs, however, challenge the propriety of this removal by asserting that Section 502(a) does not govern this action. They argue that this Court should remand the action to state court for lack of subject matter jurisdiction. As a result, this Court must review the complaint, the petition for removal, the statutes pursuant to which U.S. Healthcare removed the claim, and the relevant case law to determine whether, indeed, this court maintains subject matter jurisdiction over the action.

1. "Complete Preemption"

The jurisdictional principles governing removal are well established. "The threshold requirement is that the complaint must fall within the 'original jurisdiction' of the federal district court." Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic

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[1] Count Six also alleges that Kennedy Hospital acted negligently in "failing to timely notify U.S. Healthcare of Michelina's birth so such a visit could be arranged and/or failing to otherwise secure arrangements for such a visit prior to discharging Michelina from the hospital."

States, Inc., 958 F. Supp. 1137, 1142 (E.D. Va. 1997) (citing 28 U.S.C. § 1441 (a)). Where, as here, there is no diversity of citizenship between the parties, removal is proper only if federal question jurisdiction exists. Id. Whether federal question jurisdiction exists is determined by application of the "well-pleaded complaint rule." Id. Under this rule, federal question jurisdiction exists when a federal question is presented on the face of a plaintiff's properly pleaded complaint. Franchise Tax Bd. v. Construction Laborers Vacation Trust, 463 U.S. 1, 9-12 (1983).

There is, however, an exception to the "well-pleaded complaint rule" - the "complete preemption" exception. Under this exception, "Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 354 (3d Cir. 1995) (quoting Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63-64 (1987)). In the ERISA context, the Supreme Court has determined that the complete preemption exception supports removal of state causes of action that fit within the scope of Section 502(a). Id. Therefore, to determine whether U.S. Healthcare properly removed this action to federal court, this Court must determine whether any of Plaintiffs' claims fit within the scope of Section 502(a).

2. Scope of Section 502(a)

The United States Court of Appeals for the Third Circuit construed Section 502(a) and determined whether certain state law claims for medical malpractice fit within its scope in Dukes v. United States Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995). According to Dukes, the determination is an exercise of statutory construction beginning with "the text of the provision in question, and mov[ing] on, as need be, to the structure and purpose of the Act in which it occurs." 57 F.3d at 357 (quoting New York State Conference of Blue Cross & Blue Shield Plans

v. Travelers Ins. Co., 514 U.S. 645 (1995)). This Court now proceeds to a statutory construction analysis of each of Plaintiff's claims upon which U.S. Healthcare based federal removal jurisdiction.

3. Counts One, Two, and Five

U.S. Healthcare bases federal removal jurisdiction on Counts One, Two, and Five of Plaintiffs' Complaint. Count One alleges that U.S. Healthcare acted negligently in adopting a policy that "encouraged, pressured, and/or directly or indirectly required that its participating physicians discharge newborn infants and their mothers from the hospital within 24 hours of the infant's birth." Count Two alleges that U.S. Healthcare acted recklessly indifferent to the health consequences of its policy "governing discharge of mothers and newborns from the hospital within 24 hours of birth knowing, among other things, that many infants would be at risk for developing life-threatening disease after leaving the hospital and that these guidelines would result in life-threatening delays in the diagnosis and treatment of these diseases." Count Five alleges that U.S. Healthcare acted negligently in "adopting policies with respect to hospital utilization by its participating physicians that discouraged these physicians from re-admitting infants to the hospital when health problems were identified subsequent to the newborns original discharge from the hospital." Because of the uniqueness of these claims, this Court will conduct its own statutory construction analysis to determine whether any fit within the scope of Section 502(a).

The plain meaning of the text of Section 502(a) does not cover the three counts. Section 502(a) covers claims "to recover benefits due . . . under the terms of [the] plan." 29 U.S.C. § 1132(a)(1)(B).[2] Such a claim "is concerned exclusively with

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[2] Section 502(a) also covers claims are "to enforce . . . rights under the terms of the plan [] or to clarify . . . rights to future benefits under the

whether or not the benefits due under the plan were actually provided." Dukes, 57 F.3d at 357. Each of the counts at issue seeks to hold U.S. Healthcare accountable for adopting policies that cause its participating physicians to provide inadequate medical care to their patients. The focus of these counts is on the quality of care provided by the physician and the impact of U.S. Healthcare's policies on that quality of care. The focus is not "exclusively" on whether U.S. Healthcare provided Plaintiffs with benefits due under the plan.[3] Therefore, this Court finds that the plain meaning of the text of Section 502(a) does not cover the three counts.[4]

Even if some ambiguity exists about whether the plain meaning of the text of Section 502(a) covers the three counts, however, the legislative history, structure, and purpose of ERISA also support the conclusion that the counts do not fit within the scope of the section 502(a). The legislative history, structure, and purpose of ERISA suggest that:

> [w]hen Congress enacted [the Act] it was concerned in large part with the various mechanisms and institutions involved in the funding and payment of plan benefits. That

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terms of the plan." These claims are not at issue in this case.

[3] In fact, Plaintiffs state in their Memorandum of Law that "[t]he plan provided for 24 hours stay in the hospital and [Plaintiffs] received this 'benefit'." They further state in their Reply Memorandum that they "do not claim that Michelina was entitled to more than 24 hours under the plan and that she was refused this service."

[4] This Court will refrain from engaging in an analysis that focuses on whether Plaintiffs claims attack the "quality of benefits" received versus the "quality of benefits" received. It finds that such an analysis has limited applicability to the facts of this case. See Dukes, 57 F.3d at 358 (recognizing that "the distinction between quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear in situations . . . where the benefit contracted for is health care services rather than money to pay for such services").

> is, Congress was concerned "that owing to the inadequacy of current minimum [financial and administrative] standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered." § 2, 29 U.S.C. § 1001(a). Thus, Congress sought to assure that promised benefits would be available when plan participants had need of them and § 502 was intended to provide each individual participant with a remedy in the event that promises made by the plan were not kept.

Dukes, 57 F.3d at 357. Plaintiffs do not seek a remedy for U.S. Healthcare's failure to provide the benefits promised by its plan. Instead, they seek a remedy for the damage caused by U.S. Healthcare's negligence in the way that it structured its plan - a structure that allegedly led participating physicians to render inadequate medical care to plan beneficiaries. There is no evidence that Congress intended Section 502 to provide this remedy as well.

Both sides have cited what appear to be conflicting cases to support their respective positions.[5] As discussed above, this

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[5] In support of its argument that Plaintiffs' claims in Counts One, Two, and Five fit within the scope of Section 502(a), U.S. Healthcare cites Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc., 958 F. Supp. 1137, 1142 (E.D. Va. 1997). In Lancaster, Lancaster alleged a claim against her HMO "for the establishment of guidelines and cost standards which worked against the full and prompt diagnostic assessment [of Lancaster's brain tumor] within the accepted standard of care and for its failure to establish policies, protocols, guidelines and standards for an adequate diagnostic assessment and treatment of [Lancaster's] continuing headaches." Id. at 1141. The court held that the claim fit within the scope of Section 502(a) because it "challenge[d] an administrative decision that has the effect of denying benefits." Id. at 1147. It reasoned that "[n]otwithstanding plaintiffs' characterizations to the contrary, the gravamen of these claims is that [the HMO] purposefully established and implemented an administrative policy that had the effect of inducing [plaintiff's doctors] to deny benefits to Lancaster, thereby causing her

Court has chosen to apply its own statutory construction analysis. Having done so, it concludes that Counts One, Two, and Five of Plaintiffs' Complaint do not fit within the scope of the section 502(a).[6] Accordingly, none of these claims provides an appropriate basis for federal removal jurisdiction.

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injuries." Id. at 1146.

In response to U.S. Healthcare's argument, Plaintiffs cite Ouellette v. Christ Hospital, 942 F. Supp. 1160 (S.D. Ohio. 1996). In Ouellette, the plaintiff alleged that her HMO breached its duty of her by "limiting the hospital stays of its subscribers and enforcing those limitations by an unreasonable system of financial incentives to hospitals." Id. at 1163-64. First, the court noted that the claim focused on the relationship between the hospital and the HMO rather than the plaintiff and the HMO. Id. at 1165. Next, it found that the plaintiff's claim was "not challenging the amount of benefits but the quality of service she received." Id. The court, therefore, held that the claim was not completely preempted by ERISA, reasoning that "[s]uch a claim is separate and distinct from a claim for benefits under a plan." Id.

[6] This Court also notes that the United States Court of Appeals for the Seventh Circuit has derived a three factor test for determining whether a claim is within the scope of Section 502(a):

> (1) whether the "plaintiff is eligible to bring a claim under that section; (2) whether the plaintiff's "cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via [Section] 502(a);" and (3) whether the plaintiff's "state law claim cannot be resolved without an interpretation of the contract governed by federal law."

Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482, 1487 (7th Cir. 1996) (citations omitted) (quoting Rice v. Panchal, 65 F.3d 637, 641, 644 (7th Cir. 1995)). A heavy focus of the test is on the third factor and whether a plaintiff's state law claim . . . require[s] construing [the ERISA plan]." Rice v. Panchal, 65 F.3d 637, 644-45 (7th Cir. 1995) (quoting Lingle v. Norge Div. of Magic Chef, Inc., 486 U.S. 399 (1988)). This Court finds that Plaintiffs claims do not rest upon the terms of their plan, nor do they require this Court to construe the terms of the plan. Therefore, this Court would reach the same conclusion if it applied the Seventh Circuit's test.

3. Count Six

U.S. Healthcare also bases federal removal jurisdiction on Count Six of Plaintiffs' Complaint. Count Six alleges that U.S. Healthcare acted negligently in "not providing for [an in-home] visit by a participating provider despite assurances under its L'il Appleseed Program that such a visit would be provided and despite a telephone call . . . from the Baumans requesting this service."

Count Six states a claim that fits within the scope of Section 502(a). Courts have held that claims against an insurer for its negligence in failing to provide a benefit due under a plan fit within the scope of Section 502(a). See Dukes, 57 F.3d at 360 (discussing Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992)); Lazorko v. Pennsylvania Hosp., No. CIV.A. 96-4858, 1997 WL 158144, at *1 (E.D. Pa. March 31, 1997). Count Six alleges that U.S. Healthcare was negligent in not providing an "in-home visit" by a participating physician, a benefit that Plaintiffs claim they asked for and were entitled to under their plan. Distilled to its essence, the count states a claim against U.S. Healthcare for its negligence in failing to provide a benefit due under the plan and fits within the scope of Section 502(a).

Since Count Six fits within the scope of Section 502(a), removal of the Complaint was proper. This Court must deny Plaintiffs' Motion for Remand to New Jersey State Court pursuant to § 1447(c).[7] It will now consider U.S. Healthcare's Motion to Dismiss.

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[7] In conjunction with their Motion for Remand to New Jersey State Court, Plaintiffs seek reimbursement from U.S. Healthcare for attorney's fees incurred in filing the Motion pursuant to § 1447(c). Since this Court will deny the Motion, however, Plaintiffs are not entitled to attorney's fees.

B. U.S. HEALTHCARE'S MOTION TO DISMISS

The ERISA preemption defense stems from the ERISA preemption clause, Section 514(a). That clause sets forth that its provisions "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). "It is important to recognize that the jurisdictional doctrine of complete preemption differs from the federal defense of ERISA preemption." Lancaster, 958 F. Supp. at 1144. "The difference between complete preemption under [Section] 502(a) and [ERISA] preemption under [Section] 514(a) is important because complete preemption is an exception to the well-pleaded complaint rule that has jurisdictional consequences." Rice v. Panchal, 65 F.3d 637, 640 (7th Cir. 1995) (citing Lister v. Stark, 890 F.2d 941, 943 (7th Cir. 1989)). State law claims that are subject to ERISA preemption under Section 514(a) "are not recharacterized as claims arising under federal law," rather, "the federal law serves as a defense to the state law claim." Id.

Despite the differences between complete preemption under Section 502(a) and ERISA preemption under Section 514(a), each preemption doctrine does not exist independently of the other. Specifically, courts have held that "[w]here a claim is completely preempted under [Section] 502(a) it is necessarily preempted under [Section] 514(a)." Rice, 65 F.3d at 646 n.10; see also Lancaster, 958 F. Supp. at 1150 ("Claims completely preempted under [Section 502(a)] are, a fortiori, preempted under [Section] 514(a)."). This Court has already found that Count Six is completely preempted under Section 502(a). It is, therefore, also preempted under Section 514(a) and must be dismissed.

C. REMANDING THE REMAINDER OF THE ACTION

This Court will remand the remainder of this action to state court, including Plaintiffs' remaining pendent state-law claims

against U.S. Healthcare. "[A] district court has discretion to remand to state court a removed case involving pendent claims upon a proper determination that retaining jurisdiction over the case would be inappropriate." Carnegie-Mellon University v. Cohill, 484 U.S. 343, 357 (1988). "The discretion to remand enables district courts to deal with cases involving pendent claims in a manner that best serves the principles of economy, convenience, fairness, and comity which underlie the pendent jurisdiction doctrine." Id. Having dismissed Count Six, this Court finds that it lacks subject matter jurisdiction over the remaining claims against U.S. Healthcare. Given that (1) the action is still in its early stages and there is no evidence that any of the parties will be prejudiced by remanding the action to state court and that (2) the claim that was the basis for removal was a relatively minor claim and only one of several claims that Plaintiffs asserted against U.S. Healthcare, this Court finds that it is proper to remand the remainder of the action to state court.

III. CONCLUSION

For the reasons stated above, this Court finds that removal was proper and denies Plaintiffs' Motion for Remand to New Jersey State Court and request to assess counsel fees pursuant to 28 U.S.C. § 1447(c). Furthermore, it will dismiss Count Six since it is preempted by Section 514(a) of ERISA. Finally, since the only basis for subject matter jurisdiction has now been dismissed, this Court will enter an appropriate order remanding the remainder of the case to the Superior Court of New Jersey, Law Division, Camden County.

Dated: March __, 1998

/s/_____
STANLEY S. BROTMAN
UNITED STATES DISTRICT
JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

ORIGINAL FILED APR 1 1998
WILLIAM T. WALSH, CLERK

STEVEN BAUMAN and MICHELLE BAUMAN, Individually and as Administrators ad prosequendum of the Estate of MICHELINA BAUMAN, Deceased	:	
Plaintiffs,	:	Civil Action No.97-2905
v.	:	
U.S. HEALTHCARE, INC., KENNEDY MEMORIAL HOSPITAL, Washington Township Division, KAMILA NEMEH, M.D., and JOHN DOE(S) (1-5) .	:	**AMENDED ORDER**
Defendants.	:	

THIS MATTER having come before this Court on defendant U.S. Healthcare, Inc.'s ("U.S. Healthcare") Motion to Dismiss or, in the Alternative, for Summary Judgment and plaintiffs Steven and Michelle Bauman's ("Plaintiffs") Motion for Remand to New Jersey State Court pursuant to 28 U.S.C. § 1447(c);

The Court having reviewed the record and the submissions of the parties;

For the reasons set forth in the Court's opinion of this date;

IT IS this 1st day of April, 1998 **HEREBY**

ORDERED that Plaintiff's Motion for Remand to New Jersey State Court pursuant to 28 U.S.C. § 1447(c) is **DENIED;** and it is further

ORDERED that Plaintiff's request for assessment of attorney's fees is also **DENIED;** and it is further

ORDERED that U.S. Healthcare's Motion to Dismiss or, in the Alternative, for Summary Judgment is **GRANTED** in part, and **COUNT SIX** of Plaintiffs' Complaint is **DISMISSED** as to U.S. Healthcare only; and it is further

ORDERED that **COUNTS ONE, TWO, THREE, FOUR, FIVE, SEVEN, and EIGHT** of Plaintiffs' Complaint are remanded to the Superior Court of New Jersey, Law Division, Camden County.

No costs.

/s/
STANLEY S. BROTMAN
UNITED STATES DISTRICT JUDGE

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 98-5222, 98-5262 & 98-5263

IN RE U.S. HEALTHCARE, INC.,
Petitioner in No. 98-5222

STEVEN BAUMAN, MICHELLE BAUMAN,
Individually and as Administrators and prosequendum
of the Estate of MICHELINA BAUMAN, deceased,
Plaintiffs/Appellees/Cross-Appellants

v.

U.S. HEALTHCARE, INC.,
Defendant/Appellant/Cross-Appellee

and

KENNEDY MEMORIAL HOSPITAL,
KAMILA NEMEH, M.D., JOHN DOES (1-5)
Defendants

SUR PETITION FOR REHEARING

Present: SOLOVITER, MANSMANN, GREENBERG, SCIRICA, NYGAARD, ALITO, ROTH, McKEE, RENDELL and ALARCÓN,* Circuit Judges

The petition for rehearing filed by Petitioner U.S. Healthcare in the above-entitled case having been submitted to

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* Hon. Arthur L. Alarcón Senior Circuit Judge for the United States Court of Appeals for the Ninth Circuit, as to panel rehearing only

the judges who participated in the decision of this court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular service not having voted for rehearing by the court en banc, the petition for rehearing is denied.

By the Court,

/s/ _____
Circuit Judge

Dated: Nov 19 1998

cmh/cc: GWS
HJB
BMR
RMS
JMS
ESW

SUPERIOR COURT OF NEW JERSEY
CAMDAN COUNTY LAW DIVISION

TOMAR, SIMONOFF, ADOURIAN, O'BRIEN,
KAPLAN, JACOBY & GRAZIANO
A PROFESSIONAL CORPORATION
20 BRACE ROAD
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ATTORNEYS FOR PLAINTIFFS

STEVEN BAUMAN and MICHELLE BAUMAN, Individually and as Administrators ad prosequendum of the Estate of MICHELINA BAUMAN, deceased, Plaintiffs,	:	CIVIL ACTION
vs.	:	**COMPLAINT IN MEDICAL MALPRACTICE AND JURY DEMAND**
U.S. HEALTHCARE, INC.; KENNEDY MEMORIAL HOSPITAL, Washington Township Division; KAMILA NEMEH, M.D.; and JOHN DOES (1-5), Defendants.	:	

Plaintiffs, Steven and Michelle Bauman, individually and as Administrators ad prosequendum of the Estate of Michelina A. Bauman, residing at 311 West Collings Drive, Williamstown,

County of Gloucester, New Jersey, by way of Complaint against Defendants, say:

1. Decedent Michelina Bauman ("Michelina") was born on May 16, 1995 at Defendant Kennedy Hospital, Washington Township Division ("Kennedy Hospital"), was released from the hospital on May 17, 1995, and died at home on May 18, 1995.

2. Plaintiffs Steven Bauman and Michelle Bauman ("the Baumans") were the parents of Michelina Bauman.

3. The Surrogate of Gloucester County has granted letters of administration ad prosequendum to Steven and Michelle Bauman, and they are authorized and empowered to bring this Survivor's Action pursuant to N.J.S.A. 2A:15-3 on behalf of decedent Michelina Bauman, and also this Wrongful Death Action pursuant to N.J.S.A. 2A:31-1 et seq. for losses they have suffered individually as a result of Michelina's death.

4. Defendant U.S. Healthcare, Inc. ("U.S. Healthcare") is a corporation with corporate headquarters at 800 Jolly Road, Blue Bell, Pennsylvania, and/or its corporate subsidiaries that function as managed care providers and/or health maintenance organizations ("HMOs"). It provides, directly and through its corporate subsidiaries, health care services to its members through a network of participating physicians, hospitals, and other providers.

5. Defendant Kennedy Hospital is an accredited provider of medical and hospital services, with offices in Cherry Hill, New Jersey, located at Hurffville Cross-Keys Road, Turnersville, New Jersey, and was, at all times relevant hereto, an U.S. Healthcare participating hospital.

6. Defendant Kamila Nemeh, M.D., ("Dr. Nemeh") is a physician duly licensed to practice medicine in the State of New Jersey, with an office currently located at Fries Mill Pavilion, 188 Fries Mill Road, Building N-1, Turnersville, NJ, and was,

at all times relevant hereto, a participating U.S. Healthcare physician.

7. Plaintiffs Michelle and Steven Bauman were, at all times relevant hereto, members of U.S. Healthcare and/or its corporate subsidiary operating in New Jersey.

COUNT ONE

1. Plaintiffs repeat and re-allege every preceding paragraph of this Complaint as if fully set forth herein.

2. On March 17, 1995, pursuant to a policy promulgated and implemented by defendant U.S. Healthcare, Dr. Nemeh discharged Michelina Bauman from Kennedy Hospital, only 24 hours after her birth.

3. This U.S. Healthcare policy encouraged, pressured, and/or directly or indirectly required that its participating physicians discharge newborn infants and their mothers from the hospital within 24 hours of the infant's birth.

4. In adopting and implementing this policy for the discharge of newborn infants from the hospital within 24 hours, defendant U.S. Healthcare acted without adequate consideration of whether this policy was medically appropriate, and thus acted negligently and without due care for the health and safety of its members and their children, including Michelina Bauman.

5. At the time Michelina Bauman was discharged from Kennedy Hospital on May 16, 1995, she suffered from a Group B Strep infection.

6. As a proximate result of U.S. Healthcare's direct negligence in, among other things, adopting and implementing its 24 hour newborn discharge policy, and/or its vicarious liability for the negligence of Dr, Nemeh and/or Kennedy Hospital, who were acting as its agents, in among other things, discharging Michelina Bauman from the hospital after only 24 hours, Michelina's virulent infection went undiagnosed and

untreated, developed into meningitis, and as a result Michelina Bauman suffered greatly and eventually died on May 18, 1995, the day following her release from the hospital.

WHEREFORE, Plaintiffs Steven and Michelle Bauman demand judgment against Defendant U.S. Healthcare, individually and/or jointly and severally with other defendants, for Michelina Bauman's pain, suffering, and other damages pursuant to N.J.S.A. 2A:15-3, and damages for wrongful death under N.J.S.A. 2A:31-1 et seq., and/or other damages recoverable under the laws of this State, plus interest, and costs of suit.

COUNT TWO

1. Plaintiffs repeat and re-allege every preceding paragraph of this complaint as if fully set forth herein.

2. Defendant U.S. Healthcare adopted its policy governing discharge of mothers and newborns from the hospital within 24 hours of birth knowing, among other things, that many infants would be at risk for developing life-threatening disease after leaving the hospital and that these guidelines would result in life-threatening delays in the diagnosis and treatment of these diseases.

3. Defendant U.S. Healthcare was recklessly indifferent to, among other things, the health consequences of its policy on infants discharged from the hospital, and instead was motivated only by the financial profit that it would realize as a result of having to pay for only one day of hospitalization for mothers and newborns.

4. As a proximate result of Defendant U.S. Healthcare's reckless indifference, decedent Michelina Bauman was prevented from obtaining timely diagnosis and treatment of her infection, which, as previously described, resulted in great suffering and eventually death.

WHEREFORE Plaintiffs Steven and Michelle Bauman demand judgment against Defendant U.S. Healthcare for punitive damages sufficient to punish it for its conduct resulting in the death of Michelina Bauman and to deter it from similar conduct in the future.

COUNT THREE

1. Plaintiffs repeat and re-allege every preceding paragraph of this Complaint as it fully set forth herein.

2. Defendant Kennedy Hospital was negligent in that, among other things, pursuant to U. S. Healthcare policy, it regularly authorized and allowed discharge of newborn infants, such as Michelina Bauman, within 24 hours of birth.

3. Defendant Kennedy Hospital was also negligent in its selection, supervision, training, and/or monitoring of its pediatric staff, including Dr. Nemeh.

4. Kennedy Hospital is also vicariously liable for the negligence of Dr. Nemeh, who acted as its agent, in, among other things, discharging Michelina Bauman 24 hours after her birth.

5. As a proximate result of the direct and/or vicarious negligence of Kennedy Hospital, decedent Michelina Bauman was prevented from obtaining timely diagnosis and treatment of her infection, which, as previously described, resulted in great suffering and eventually death.

WHEREFORE Plaintiffs demand judgment against Defendant Kennedy Hospital, individually and/or jointly and severally with other defendants, for decedent Michelina Bauman's pain, suffering, and other damages pursuant to N.J.S.A. 2A:15-3, and damages wrongful death under N.J.S.A. 2A:31-1 et. seq., and/or other damages recoverable under the laws of this State, plus interest, and cost of suit.

COUNT FOUR

1. Plaintiffs repeat and re-allege every preceding paragraph of this Complaint as if fully set forth herein.

2. At all times relevant herein, Dr. Nemeh was the pediatrician directly responsible for the examination, care, diagnosis and treatment of Michelina Bauman.

3. Dr. Nemeh acted negligently in, among other things, discharging Michelina Bauman, who was suffering from Group B Strep infection, from Kennedy Hospital on May 17, 1995.

4. During the evening following Michelina's discharge from the hospital, plaintiffs Michelle & Steven Bauman gradually became more and more concerned about Michelina's health.

5. Beginning at 6:00 a.m. on May 18, 1995, and several times thereafter during that day, plaintiffs Michelle and Steven Bauman telephoned Dr. Nemeh, reporting Michelina's symptoms and expressing their concerns about her health.

6. In response to these calls, Dr. Nemeh acted negligently by failing generally to provide adequate medical advice, and failing specifically to advise the Baumans to bring Michelina to the hospital to receive immediate medical attention.

7. As a proximate result of Dr. Nemeh's negligence, Michelina was prevented from obtaining timely diagnosis and treatment of her infection, which, as previously described resulted in great suffering and eventually death.

WHEREFORE Plaintiffs Steven and Michelle Bauman demand judgment against Defendant Dr. Kamila Nemeh, individually and/or jointly and severally with other defendants, for decedent Michelina Bauman's pain, suffering, and other damages pursuant to N.J.S.A. 2A:15-3, and damages for wrongful death under N.J.S.A. 2A:31-1 et seq., and/or other

damages recoverable under the laws of this State, plus interest, and costs of suit.

COUNT FIVE

1. Plaintiffs repeat and re-allege every preceding paragraph of this Complaint as if fully set forth herein.

2. Defendant U.S. Healthcare was also negligent in, among other things, adopting policies with respect to hospital utilization by its participating physicians that discouraged these physicians from re-admitting infants to the hospital when health problems were identified subsequent to the newborns original discharge from the hospital.

3. As a result of this policy, Dr. Nemeh failed to advise the Baumans to return Michelina to the hospital for immediate medical attention on May 18, 1995.

4. Defendant U.S. Healthcare was also negligent in failing to exercise due care in the selection, supervision, training, and/or monitoring of Dr. Nemeh as a participating provider of health services.

5. As a proximate result of U.S. Healthcare's direct negligence and its vicarious liability for the negligence of Dr. Nemeh, who was acting as its agent, Michelina was prevented from obtaining timely diagnosis and treatment of her infection, which, as previously described, resulted in great suffering and eventually death.

WHEREFORE Plaintiffs demand judgment against Defendant U.S. Healthcare, individually and/or jointly and severally with other defendants, for decedent Michelina Bauman's pain, suffering and other damages pursuant to N.J.S.A. 2A:15-3, and damages for wrongful death under N.J.S.A. 2A:31-1 et seq., and/or other damages recoverable under the laws of this State, plus interest, and costs of suit.

COUNT SIX

1. Plaintiffs repeat and re-allege every preceding paragraph of this Complaint as if fully set forth herein.

2. Because Michelina Bauman was discharged from the hospital within 24 hours, medically appropriate care required an in-home visit of Michelina by a pediatric nurse immediately after discharge to ensure the baby's health and well-being.

3. Defendant U.S. Healthcare was negligent in, among other things, not providing for such a visit by a participating provider despite assurances under its L'il Appleseed Program that such a visit would be provided and despite a telephone call on May 18, 1995 from the Baumans requesting this service.

4. Defendant Kennedy Hospital was negligent in, among other things, failing to timely notify U.S. Healthcare of Michelina's birth so such a visit could be arranged and/or failing to otherwise secure arrangements for such a visit prior to discharging Michelina from the hospital on May 17th.

5. Defendant Dr. Nemeh was negligent in, among other things, failing to verify that arrangements for such a visit had been secured prior to discharging Michelina from the hospital on May 17th.

6. As a proximate result of defendants' negligence, decedent Michelina Bauman was prevented from obtaining timely diagnosis and treatment of her infection, which, as previously described, resulted in great suffering and eventually death.

WHEREFORE Plaintiffs Steven and Michelle Bauman demand judgment against Defendants, individually and/or jointly and severally, for decedent's Michelina Bauman's pain suffering, and other damages pursuant to N.J.S.A. 2A:15-3, and damages for wrongful death under N.J.S.A. 2A:31-1 et seq.,

and/or other damages recoverable under the laws of this State, plus interest, and costs of suit.

COUNT SEVEN

1. Plaintiffs repeat and re-allege every preceding paragraph of this Complaint as if fully set forth herein.

2. Defendant John Does (1-5) are fictitious names for HMOs, managed care providers, health insurers, health care f acuities, physicians, and/or other health care personnel or providers, as yet unidentified, who participated directly or indirectly in the medical care of Michelina Bauman.

3. Defendant John Does (1-5) acted negligently to the extent that, among other things, they participated directly or indirectly in the decision to discharge Michelina Bauman from Kennedy Hospital 24 hours after her birth.

4. Defendant John Does (1-5) acted negligently to the extent that, among other things, they participated directly or indirectly in the failure to give adequate general medical advice to the Baumans on May 18, 1997, including the specific failure to advise the Baumans to return Michelina to the hospital for immediate medical attention.

5. Defendant John Does (1-5) acted negligently to the extent that, among other things, they participated directly or indirectly in the failure to secure an in-home visit of Michelina by a pediatric nurse immediately after discharge.

6. As a proximate result of Defendants John Does (1-5) negligence, decedent Michelina Bauman was prevented from obtaining timely diagnosis and treatment of her infection, which, as previously described, resulted in great suffering and eventually death.

WHEREFORE Plaintiffs Steven and Michelle Bauman demand judgment against Defendants, individually and/or jointly and severally, for decedent's Michelina Bauman's pain

suffering, and other damages pursuant to N.J.S.A. 2A:15-3, and damages for wrongful death under N. J. S.A. 2A:31-1 et seq., and/or other damages recoverable under the laws of this State, plus interest, and costs of suit.

COUNT EIGHT

1. Plaintiffs repeat and re-allege every preceding paragraph of this Complaint as if fully set forth herein.

2. Defendants breached their duty to provide reasonable medical care to plaintiffs Michelle and Steven Bauman by, among other things, authorizing the discharge of Michelle and Michelina Bauman from the hospital after only 24 hours, against the Baumans' wishes and without informing them of the potentially dangerous consequences of this very early release.

3. The Baumans also directly observed the defendants' breach of their duty to provide reasonable medical care to their daughter, Michelina, by, among other things, discharging her from the hospital within 24 hours, and by, subsequent to the discharge, failing to adequately respond to reports of Michelina's symptoms, despite numerous phone calls by her parents.

4. The Baumans were present with Michelina during the entire time after her discharge from the hospital on May 17th and directly observed the terrible physical and emotional pain and suffering of their newborn daughter Michelina up to and including her eventual death the following day, which was the result of and connected to the breach of duty by defendants.

5. As a proximate result of defendants' negligence, plaintiffs have suffered and will continue to suffer severe emotional and mental distress.

WHEREFORE Plaintiffs Steven and Michelle Bauman demand judgment against all defendants, individually and/or jointly and severally with other defendants for all damages

recoverable under the laws of this State, plus interest, and costs of suit.

TOMAR, SIMONOFF, ADOURIAN, O'BRIEN, KAPLAN, JACOBY & GRAZIANO

BY: /s/_____
JOSHUA M. SPIELBERT

DATED: 5/12/97

DEMAND FOR JURY TRIAL

Plaintiffs hereby demand trial by jury.

TOMAR, SIMONOFF, ADOURIAN, O'BRIEN, KAPLAN, JACOBY & GRAZIANO

BY: /s/_____
JOSHUA M. SPIELBERT

Supreme Court, U.S.
FILED
APR 17 2000
CLERK

No. 99-1383

In The

Supreme Court of the United States

U.S. HEALTHCARE, INC.,

Petitioner,

v.

STEVEN BAUMAN AND MICHELLE BAUMAN,
Individually and as Administrators *ad prosequendum*
of the Estate of Michelina Bauman, deceased,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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23 pp

QUESTION PRESENTED

This is a state law medical malpractice action. In addition to naming the doctor and hospital as defendants, plaintiffs Steven and Michelle Bauman named a non-traditional defendant – their health maintenance organization (HMO), U.S. Healthcare. Defendant U.S. Healthcare removed this medical malpractice action to federal court claiming that because the Baumans received their health benefits pursuant to an "employee benefit plan" subject to the Employee Retirement Security Act (ERISA), 29 U.S.C. §§1001-1461, their claims against U.S. Healthcare were "completely preempted" under section 502(a) of ERISA, 29 U.S.C. §1132(a). The United States Court of Appeals for the Third Circuit rejected U.S. Healthcare's arguments, finding that none of the Baumans' claims was preempted under Section 502(a), and remanded the case to state court.

The question presented is:

> Does Section 502(a) of ERISA "completely preempt" state law medical malpractice claims against an HMO that are based on the HMO providing or causing others to provide medical treatment that falls below the standard of care simply because the injured party's medical care was provided pursuant to an employee benefit plan subject to ERISA?

Moreover, Petitioner's statement of the Question Presented misstates the facts. Plaintiffs' claims *are* based on actions taken in the course of treatment, e.g., the action of discharging Michelina from the hospital only twenty-four hours after birth and the action of failing to re-admit

QUESTION PRESENTED – Continued

Michelina to the hospital the following day when the parents reported her symptoms. For both actions, plaintiffs assert that U.S. Healthcare's policies were a substantial contributing cause.

PARTIES

The parties to this action are defendant U.S. Healthcare, Inc. (Petitioner) and plaintiffs Steven and Michelle Bauman, individually and on behalf of their deceased daughter, Michelina Bauman (Respondents). The other parties are defendants Kennedy Memorial Hospital and Dr. Kamila Nemeh, who have not participated actively in the proceedings in federal court.

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OPINIONS BELOW

The opinion of the Third Circuit is reported at 193 F.3d 151. The opinion of the District Court is reported at 1 F. Supp. 2d 420.

JURISDICTION

Petitioner claims "federal question" subject matter jurisdiction under 28 U.S.C. §1331, a contention rejected by the Third Circuit. The Third Circuit rendered its decision on September 16, 1999, and denied U.S. Healthcare's petition for rehearing en banc on November 19, 1999. Petitioner's App. (hereinafter "App.") 42a-43a. Petitioner invokes this Court's appellate jurisdiction pursuant to 28 U.S.C. §1254(1).

STATUTORY PROVISIONS

Section 502(a) of ERISA, 29 U.S.C. §1132(a)(1)(B), provides:

> (a) A civil action may be brought –
>
> (1) by a participant or beneficiary –
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]

STATEMENT OF THE CASE

A. Facts

Michelle Bauman gave birth to her first child, Michelina Bauman, on May 16, 1995, at Kennedy Memorial Hospital in Washington Township, New Jersey. App. 45a. Pursuant to the "twenty-four-hour discharge" policy of Michelle Bauman's U.S. Healthcare HMO,[1] Dr. Kamila Nemeh (Michelina's pediatrician) discharged Michelina Bauman from the hospital the next day, May 17, 1995, approximately twenty-four hours after she was born. Dr. Nemeh failed to diagnose that Michelina was suffering from a Group B strep infection prior to discharge. App. 46a.

Beginning at 6:00 a.m. on the day following discharge, May 18, 1995, Steven and Michelle Bauman telephoned Dr. Nemeh several times to report symptoms indicating Michelina was ill. Dr. Nemeh failed to arrange for the Baumans to have Michelina re-admitted to the hospital. App. 49a. In addition, on May 18, 1995, the Baumans telephoned U.S. Healthcare's L'il Appleseed Program and requested an immediate in-home visit by a pediatric nurse to evaluate Michelina. U.S. Healthcare failed to respond to this request. App. 51a. Michelina Bauman died later in the day on May 18, 1995, at two days old, from meningitis caused by the Group B strep infection that went undiagnosed, and consequently, untreated. App. 46a-47a.

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[1] U.S. Healthcare has identified the Health Maintenance Organization of New Jersey, Inc. ("HMO-NJ") as its subsidiary.

B. Procedural History

The Baumans filed this medical malpractice action in New Jersey Superior Court on May 12, 1997. App. 44a-54a. They alleged malpractice by defendants U.S. Healthcare, Kennedy Memorial Hospital, and Dr. Nemeh. Almost immediately, U.S. Healthcare filed its Notice of Removal to federal court, claiming federal question jurisdiction. U.S. Healthcare contended that plaintiffs' state law medical malpractice claims against it were transformed into claims "to recover benefits due" under Section 502(a) of ERISA simply because the Baumans received their health care benefits through a health care plan subject to ERISA.

In addition to claims against U.S. Healthcare for vicarious liability and for negligent selection and supervision of Dr. Nemeh, plaintiffs' Complaint focused on three separate actions by U.S. Healthcare that either constituted medical malpractice or caused it to occur. The first action was U.S. Healthcare's decision to adopt a twenty-four-hour discharge policy, which, plaintiffs alleged in Counts One and Two, was a substantial factor in causing Michelina Bauman to be discharged from the hospital too soon. The second action was U.S. Healthcare's decision to adopt a policy discouraging hospital admissions, which, plaintiffs alleged in Count Five, was a substantial factor in Dr. Nemeh's decision not to re-admit Michelina to the hospital the next day despite serious symptoms of illness. The third action, alleged in Count Six, was U.S. Healthcare's negligent failure to provide the Baumans with a timely in-home visit from a pediatric nurse.

Plaintiffs moved to remand this action to state court, asserting that all claims against U.S. Healthcare were medical malpractice claims, not claims to "recover benefits due" under section 502(a) of ERISA. The Honorable Stanley S. Brotman, U.S. District Judge, agreed that plaintiffs' claims against U.S. Healthcare for its twenty-four-hour discharge policy and its policies discouraging hospital re-admissions were medical malpractice claims. He concluded "that Counts One, Two and Five of Plaintiffs' Complaint do not fit within the scope of section 502(a)." App. 36a. The district court interpreted Count Six, however, as stating a claim for "failing to provide a benefit due under the plan [which] fits within the scope of Section 502(a)." App. 37a. Since Judge Brotman found this claim completely preempted under section 502(a), it followed that it was preempted under ERISA's express preemption provision, section 514(a), 29 U.S.C. §1144(a). He therefore dismissed Count Six against U.S. Healthcare, but remanded all remaining claims against U.S. Healthcare and the other defendants to New Jersey state court. App. 37a-39a.

On appeal, the Third Circuit held that none of the claims against U.S. Healthcare was completely preempted. It therefore reversed the dismissal of Count Six and ordered remand of the entire case to state court. App. 22a.

In affirming Judge Brotman's holding that Counts One, Two, and Five were not completely preempted under Section 502, the Third Circuit relied on several factors. First, the court examined the specific language of Section 502 referring to an "action . . . to recover benefits due . . . under the terms of the plan," and noted that "the

Baumans do not claim anywhere in these counts that they were denied any of the benefits that were due under the plan." App. 17a. Second, the court reiterated the distinction drawn in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995), between claims directed to the *quality* of care provided, which are not completely preempted, and claims that a plan participant did not receive a *quantity* of benefits due under the terms of his plan. The court observed that the applicable counts of the Baumans' Complaint "are phrased in terms of the quality of medical care provided." 18a. Finally, the Third Circuit emphasized the distinction between claims against an HMO acting in its role as administrator of health benefits, which are preempted, and claims against an HMO acting in its role as provider or arranger of medical services, which are not. The court concluded that these counts did not address "plan administration decisions, but rather decisions that the HMO allegedly made in the course of arranging for the provision of medical services." App. 19a.

In reversing the district court's finding that Count Six was completely preempted, the Third Circuit declared: "the mere fact that the Baumans referred in their complaint to a benefit promised by their health care plan does not automatically convert their state law negligence claim into a claim for benefits under section 502." App. 21a. Instead, the court determined that Count Six was not preempted based on another important distinction: this count was premised on U.S. Healthcare's failure to meet the standard of care under state tort law, rather than a violation of a contractual promise made to the Baumans in their ERISA plan. App. 20a-21a.

ARGUMENT

I. THE DECISION BELOW IS CONSISTENT WITH DECISIONS BY OTHER COURTS OF APPEALS.

Contrary to the statements in the Petition for Certiorari, Pet. 7, the Baumans' Complaint **does** allege that the medical care provided to their baby Michelina while she was at Kennedy Memorial Hospital was inadequate, and **does** allege that the medical diagnosis and treatment was improper. The Baumans allege that U.S. Healthcare's twenty-four-hour discharge policy caused Michelina, who was suffering from a Group B strep infection, to receive care that was medically inadequate on May 17, 1995, namely the care necessary to promptly diagnose and treat this infection. In addition, the Baumans allege that U.S. Healthcare's policy regarding hospital admissions caused Michelina to receive medically inadequate care on May 18, 1995, namely the care necessary to promptly diagnose and treat this infection through rehospitalization. Finally, the Baumans allege that U.S. Healthcare's negligence in failing to provide a timely in-home visit by a pediatric nurse caused Michelina to receive medically inadequate care, namely the care necessary to enable another medical professional to diagnose this infection and arrange for immediate treatment.

On the other hand, unlike every case from other courts of appeals that Petitioner cites as supporting its argument, the Baumans do **not** allege that they requested medical treatment that was denied by their health care plan. Regarding Count One, the Third Circuit stated:

> This is not a claim that a certain benefit was requested and denied. . . . U.S. Healthcare's

> policy and incentive structure were such that "the Baumans never had the option of making an informed decision as to whether to pay for the hospitalization themselves," as would occur in a situation in which coverage is sought and denied.

In re U.S. Healthcare, Inc., 193 F.3d 151, 163 (3d Cir. 1999).

Regarding Counts One, Two, and Five, the Third Circuit further concluded that "none of these counts . . . alleges a failure to provide or authorize benefits under the plan, and the Baumans do not claim anywhere in these counts that they were denied any of the benefits that were due under the plan." *Id.* at 162. In addition, even though Count Six referred to a benefit (an in-home pediatric nurse visit) promised by U.S. Healthcare, it was not a benefit that U.S. Healthcare denied or for which it refused to authorize payment pursuant to its role as benefits administrator, but rather a service that it negligently failed to promptly arrange for in its role as medical provider. *Id.* at 164.

In this case, the absence of a denied request for benefits by an HMO, acting in its role as benefits administrator, stands in stark contrast to every case from other circuits that the Petitioner claims are conflicting. Each of the cases cited by Petitioner involves a specific request to the HMO, acting as benefits administrator, for a benefit under the plan and a specific denial of that request for benefits by the HMO as not covered by the plan.

For example, Petitioner cites *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999), as primary support for its argument that the case below conflicts with decisions by numerous other courts of appeals. Pet.

8. Yet, *Danca* involved a request for specific benefits and a denial of that coverage under an ERISA plan. Pamela Danca, who had a long history of mental illness, sought care for a new episode of mental illness in September 1994. Her physician requested treatment at a specific psychiatric hospital (McLean) where she had been successfully treated in the past. Pursuant to a utilization review process, defendants "*denied* precertification for treatment at McLean and instead precertified Danca's admission to Emerson Hospital." 185 F.3d at 3 (emphasis added). Later, allegedly as a result of inadequate care at Emerson Hospital, Danca attempted suicide by self-immolation and sustained horrific injuries. On the basis of this denial of specific benefits pursuant to utilization review, the First Circuit concluded Danca's claims were properly characterized as an "alternative enforcement mechanism" to a Section 502(a) action to recover benefits due. *Id.* at 5. No such denial of specific benefits pursuant to a utilization review process or anything similar occurred in the claims asserted by the Baumans in the case below.

"Utilization review" or "pre-certification review" is a process whereby plan participants must obtain advance approval for certain medical procedures or hospitalizations. When a patient's physician recommends a particular treatment, the HMO or its designee performs an independent review to determine whether the plan will authorize (i.e., pay for) the physician's recommended treatment. *See Dukes*, 57 F.3d at 359; *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331-32 (5th Cir.), cert. denied, 506 U.S. 1033 (1992).

Petitioner now refers to its twenty-four-hour discharge policy as an "administrative pre-certification review policy" in a blatant attempt to characterize the instant case as one, like *Danca*, involving utilization or pre-certification review. This characterization must fail, however, because there are fundamental differences between Petitioner's twenty-four-hour discharge policy and actual pre-certification review. Pre-certification review is a *process* involving an administrative determination; in contrast, twenty-four-hour discharge was a *policy* that impacted upon providers' medical decision-making. As the Third Circuit observed, U.S. Healthcare policies "adversely influenced the medical judgment of its participating providers." 193 F.3d at 163. In pre-certification review, the administrator's benefits decision is controlling; in contrast, under twenty-four-hour discharge, the medical provider's decision was discretionary. As the Third Circuit noted, "U.S. Healthcare's statement at oral argument that the twenty-four hour pre-certification policy is not a hard and fast rule and can be extended as the doctor sees fit only reinforces the view that it is a discretionary medical decision rather than an administrative one." *Id.* at 164.

For these reasons, Petitioner's reliance on *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072 (8th Cir. 2000), to support its argument alleging a conflict within the circuit courts is similarly unavailing. *Thompson*, unlike the decision below, involved a request for specific benefits that was denied by the entity administering the patient's health care benefits. Mrs. Thompson suffered from breast

cancer, and her treating physicians requested authorization from Gencare for high-dose chemotherapy accompanied by an autologous bone marrow transplant. "Gencare *declined* to pre-certify this treatment." 202 F.3d at 1073 (emphasis added). Because this claim involved a benefits administrator denying authorization for payment for a requested benefit not covered under the plan, the Eighth Circuit held it was completely preempted under Section 502. This result does not conflict in any way with the decision below which does not involve any claims that were denied as not covered by the plan.

Petitioner also claims that *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999), conflicts with the decision below. Yet, *Hull* also involved a request for a specific benefit (a thallium stress test) by the plaintiff's primary care physician that was denied by the plan administrator. "Dr. Fallon, the Plan's administrator . . . *denied both requests* for a thallium stress test and instead authorized a treadmill stress test." 188 F.3d at 941 (emphasis added). The Eighth Circuit concluded that because Dr. Fallon "denied the thallium tests as part of a determination of benefits owed by the Plan[,]" the plaintiff's claims were preempted by Section 502(a) of ERISA. *Id.* at 943.

All of the other cases finding complete preemption under Section 502 of ERISA (or conflict preemption under Section 514 of ERISA) cited by Petitioner, Pet. 10-11, show the same pattern of a specific treatment that was requested by a patient or her physician, followed by a specific denial of this benefit by a person making a determination of benefits under the plan. *See Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996) (Jass requested physical therapy for her knee after knee

replacement surgery, which the HMO's utilization review administrator denied as not medically necessary); *Cannon v. Group Health Serv., Inc.*, 77 F.3d 1270 (10th Cir.), cert. denied, 519 U.S. 816 (1996) (Cannon's physician requested authorization for an autologous bone marrow transplant to treat her leukemia but it was denied by her HMO pursuant to a specific provision in her plan); *Parrino v. FHP, Inc.*, 146 F.3d 699 (9th Cir.), cert. denied, 525 U.S. 1001 (1998) (Parrino's physicians, after removal of a brain tumor, prescribed proton beam therapy to reduce the chance of recurrence, but the HMO administering Parrino's health plan initially refused to authorize payment for the therapy claiming it was experimental and unnecessary); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995) (Tolton requested in-patient psychiatric care for his suicidal tendencies, but this care was not authorized by the entity providing mental health benefits to plan participants); *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298 (8th Cir. 1993), cert. denied, 510 U.S. 1045 (1994) (Kuhl's physicians requested authorization for specialized heart bypass surgery at a hospital in St. Louis, but a utilization review coordinator refused to pre-certify payment for the surgery because the hospital was outside the service area covered by the plan); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), cert. denied, 506 U.S. 1033 (1992) (Corcoran's physician sought approval for hospitalization because of high risk pregnancy, but utilization review entity denied authorization based on its determination that hospitalization was not necessary).

The decision below conflicts with none of the above cases cited by Petitioner because, unlike all of those cases,

the Baumans' claims do **not** involve a request for treatment followed by a denial of benefits requested under their plan. Moreover, the decision below is consistent with cases from a number of other courts of appeals that find no ERISA preemption in situations where there is no request for and denial of benefits. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995) (claims against HMOs for vicarious liability of plan physicians and for negligent selection and supervision of those physicians not preempted under section 502 of ERISA because they involve quality, not quantity, of benefits, and do not involve utilization review); *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269 (2d Cir. 1994) (claim against health care entity for negligent hiring and supervision of psychotherapist is not a suit "to recover benefits due" under Section 502 of ERISA); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) (claim that HMO is vicariously liable for malpractice of physician provider not properly recharacterized as claim within Section 502 of ERISA); *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332 (5th Cir. 1999) (claims against HMO for vicarious liability and negligent selection of physician who failed to diagnose heart defect not completely preempted under section 502 of ERISA); *Pacificare of Okla. v. Burrage*, 59 F.3d 151 (10th Cir. 1995) (claim that HMO vicariously liable for medical malpractice of primary care physician not preempted under Section 514 of ERISA).

II. THIS COURT'S REVIEW IS UNNECESSARY BECAUSE THE DECISION BELOW ADDS CLARITY, NOT CONFUSION, TO THIS AREA OF THE LAW.

The above discussion demonstrates that there is actually a remarkable amount of consistency among the various courts of appeals that have considered whether state law medical malpractice claims are completely preempted by, and therefore properly re-characterized as claims under, Section 502 of ERISA. In those cases in which a plaintiff's claim is based on failure to provide medical treatment that was requested but denied pursuant to a benefits determination under an ERISA plan, the courts of appeals have found preemption under section 502 of ERISA. In all other cases, the circuit courts have found no preemption under Section 502. The decision below falls within this latter category.

While Respondents agree with Petitioner that this issue is important because "ERISA affects virtually all Americans who obtain health benefits through a private employer," Pet. 13, Respondents do not agree that complete preemption under ERISA "will continue to perplex and divide the federal courts until this Court steps in." Pet. 16. Rather, the courts of appeals have developed an evolving jurisprudence on this issue with much consensus. The decision below represents an important doctrinal step forward in this evolving jurisprudence that will further clarify this issue in the lower courts.[2]

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[2] For a number of reasons, the quotes from the periodical articles cited by Petitioner are not convincing evidence that there is general confusion on Section 502 complete preemption.

What is important about the case below is that it elucidates two tests courts can apply to determine whether a particular medical malpractice claim is completely preempted by Section 502. The first helpful test provided by the court is based on understanding the dual role of the HMO in today's managed care environment: "the same HMO may have assumed both the role as a plan administrator and the separate role as a provider of medical services." *In re U.S. Healthcare,* 193 F.3d at 162. Using this test, the Court was able to categorize the Baumans' claim based on U.S. Healthcare's twenty-four-hour discharge policy as directed at "the HMO's role in 'arranging for medical treatment' rather than its role as a plan administrator determining what benefits are appropriate." *Id.* Similarly, Count Six of the Baumans' Complaint is not preempted under Section 502 because it is "directed toward the HMO's action in its capacity as a medical provider, rather than as a benefits administrator." *Id.* at 164.

Even more important than the distinction the decision below draws between the HMO acting as plan

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First, three of the articles are from 1996, when the law in this area was just beginning to evolve. Second, the credentials of the authors are unknown and it is not uncommon for authors to justify their articles by referring to confusion in the law. Third, the articles apparently refer to all federal cases, rather than to courts of appeals cases which are important here. Finally, the quotes refer to ERISA preemption generally, making no distinction between complete preemption under Section 502 and conflict preemption under Section 514; this indicates that either the authors of these articles are confused themselves about this area of law or that the confusion they refer to may relate to Section 514, which is not at issue in this case.

administrator and the HMO acting as medical provider or arranger is the distinction drawn between actions based on the standard of care and those based on rights created by the ERISA plan. The court held that Count Six was not completely preempted under Section 502 because it presented "a cause of action for violating a tort duty 'to provide [the Bauman family] adequate medical care, rather than a violation of a [contractual] promise . . . made to them in their ERISA plan.' " *Id.* The court further opined that if U.S. Healthcare "failed to meet the *standard of care* required of healthcare providers by failing to arrange for a pediatric nurse in a timely manner, Count Six sets forth an ordinary state-law tort claim for medical malpractice." *Id.* (emphasis added).

This focus on whether plaintiffs' claims for alleged medical malpractice are based on requirements under the standard of care (as opposed to requirements under the ERISA plan) is present throughout the Third Circuit's decision. For example, the court analyzes U.S. Healthcare policies encouraging twenty-four-hour discharge and discouraging the re-admission of newborns as conflicting with what the "appropriate standard of care required otherwise under state law." *Id.* at 163. This focus is crucial because it analyzes the true nature of plaintiffs' claims as alleged in their Complaint. It therefore adds additional clarity to the inquiry under Section 502 preemption analysis as to whether plaintiffs' claim should be "properly re-characterized" as a claim under Section 502 of ERISA. Since the decision below is not only consistent with, but also provides additional clarity to, existing law in this area, there is no need for this court to intervene.

CONCLUSION

For all of the reasons stated above, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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April 2000

(3)

No. 99-1383

Supreme Court, U.S.
FILED
MAY 2 - 2000
CLERK

In the Supreme Court of the United States

U.S. HEALTHCARE, INC.,
Petitioner,

v.

STEVEN BAUMAN AND MICHELLE BAUMAN,
Individually and as Administrators *ad prosequendum*
of the Estate of Michelina Bauman, deceased,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

REPLY BRIEF FOR PETITIONER

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REPLY BRIEF FOR PETITIONER

We demonstrated in the petition that the lower courts are in hopeless disarray on the question of when a tort action against an HMO may be removed to federal court because of complete preemption under ERISA Section 502(a). Respondents themselves concede the importance of the question. See Br. in Opp. 13. Rather than acknowledging that the lower courts are profoundly divided on this recurring issue, however, respondents characterize preemption jurisprudence as merely "evolving," *ibid.*, and offer an unsupported distinction to attempt to harmonize the decision below with those of other courts of appeals. Examination of respondents' proposed unifying principle — that a formal request-and-denial is required for preemption — only strengthens the case for review in this Court.

1. As we explained in the petition (at 7-13), the decision below directly conflicts with those of a number of other courts of appeals, which have held that claims challenging benefits determinations like the pre-certification policy here are completely preempted by Section 502(a). As those courts have explained, such claims are in reality actions "to recover benefits due * * * under the terms of [a] plan, to enforce * * * rights under the terms of [a] plan, or to clarify * * * rights to future benefits under the terms of [a] plan." 29 U.S.C. § 1132(a)(1)(B). A determination that a particular course of treatment will not be covered, or that coverage for a hospital stay will be limited to a prescribed length of time, is "part of the process used to assess a participant's claim for a benefit payment under the plan." *Danca* v. *Private Health Care Sys., Inc.*, 185 F.3d 1, 5-6 (1st Cir. 1999). It thus falls under the scope of complete preemption under Section 502(a) even if the challenged conduct involves medical consultation and decisionmaking. *Ibid.*; see also, *e.g.*, *Kuhl* v. *Lincoln Nat'l Health Plan, Inc.*, 999 F.2d 298, 302-303 (8th Cir. 1993); *Jass* v. *Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488-1489 (7th Cir. 1996).

Respondents acknowledge (Br. in Opp. 7) that determinations made by an HMO "acting in its role as benefits administrator" are completely preempted by Section 502(a). Respondents contend that this case is different, however, because the coverage they now allege they were due was never formally requested and denied. See Br. in Opp. 7.[1] Again and again in their brief (*id.* at 6-11), respondents rely on this alleged distinction to try to smooth over the stark conflict created by the decision below.

Respondents' "distinction," which is newly minted for the benefit of this Court, does nothing to harmonize this conflict. Just as an HMO acts as a benefits administrator when it applies general coverage guidelines to decide whether to approve payment for a particular course of treatment for a patient, so too does it act in its administrative role when it takes the earlier step of adopting those general coverage guidelines. Quite obviously, an HMO cannot conduct utilization or pre-certification review until it has first adopted general guidelines for coverage. If the application of those general guidelines in an individual case is benefits administration subject to complete preemption under Section 502(a) — as numerous courts of appeals have held — then *a fortiori* the adoption of those guidelines must also be subject to complete preemption under that section.

This obvious point is fatal to respondents' attempted distinction (Br. in Opp. 9) between the "process" of utilization or pre-

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[1] Even this distinction, moreover, is facially inapplicable to Count 6, which the district court below held to be completely preempted. Pet. App. 37a. Respondents allege in Count 6 that U.S. Healthcare was negligent in failing to "provid[e] for * * * a visit by a participating provider despite assurances * * * that such a visit would be provided and despite a telephone call on May 18, 1995 from the Baumans requesting this service." Pet. App. 51a. According to that allegation, U.S. Healthcare effectively denied a benefit that respondents had requested (an in-home visit by a participating provider on May 18, 1995).

certification review and the "policy" to cover twenty-four hours of hospitalization following a normal birth. In any "process" of utilization or pre-certification review, there is a general coverage "policy" being applied. See *Danca*, 185 F.3d at 5 & n.5. Indeed, if anything, adoption of the general guidelines ***more*** obviously constitutes benefits administration than does utilization or pre-certification review, since it does not involve quasi-medical consultation or treatment decisions.[2] Cf. *Danca*, 185 F.3d at 5. In any event, however, the former constitutes "benefits administration" at least as much as does the latter, and the distinction respondents rely on has no force.[3]

Respondents' assertion that Ms. Bauman and Michelina Bauman were wrongfully discharged from the hospital as a result of U.S. Healthcare's failure to authorize a general policy of more expansive inpatient coverage following childbirth is functionally indistinguishable from challenges to pre-certification and utilization reviews: both types of challenges attack

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[2] This case is thus similar to *Pegram* v. *Herdrich*, No. 98-1949 (argued Feb. 23, 2000), in that both cases involve cost-containment features that relate to plan design. At the very least, therefore, the Court should defer action on this petition pending the outcome of *Pegram*, as well as a decision on the pending petition for certiorari in *United States Healthcare Systems, Inc.* v. *Pennsylvania Hosp. Ins. Co.*, No. 98-1836, which the Solicitor General urged this Court to hold pending the disposition of *Pegram* and to grant for full briefing and argument on the merits if the issues that petition raises are not fully disposed of in *Pegram*.

[3] Thus the "allegedly negligent decisionmaking" here, though it "may be characterized as medical in nature," and even though it "was not in itself a final 'benefits' determination," "was indisputably part of the process used to assess a participant's claim for a benefit payment under the plan. As such, any state-law-based attack on this conduct would amount to an [impermissible] 'alternative enforcement mechanism' * * *." *Danca*, 185 F.3d at 5-6 (quoting *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 56 (1987)).

conduct that is part of a prospective coverage determination. To put it another way, both kinds of claims challenge an HMO's determinations about "what [a] medical plan will pay for," which are "part and parcel of its [administrative] mandate to decide what benefits are available under [a] plan." *Corcoran* v. *United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992). The unanimous view of the courts of appeals other than the court below, as we have explained, is that coverage determinations about what an HMO will pay for are completely preempted under Section 502(a). See *Thompson* v. *Gencare Health Sys., Inc.*, 202 F.3d 1072, 1073-74 (8th Cir. 2000); *Hull* v. *Fallon*, 188 F.3d 939, 943 (8th Cir. 1999), cert. denied 120 S. Ct. 1242 (2000); *Danca*, 185 F.3d at 6; *Jass*, 88 F.3d at 1489; *Corcoran*, 965 F.2d at 1332; see also Pet. 8-10. The decision of the court below conflicts with those unanimous holdings.

Respondents argue that this case is not an action to recover benefits because there was never a formal denial of a request for care and they do not frame their claim as one for benefits due. See Br. in Opp. 7. What respondents fail to grapple with, however, is that the claims other courts have found completely preempted under Section 502(a) are never ***framed*** as a claim for benefits due under an ERISA plan, but instead are always pleaded as state-law tort claims. Complete preemption under Section 502(a) is a means of ***recharacterizing*** a plaintiff's claims, usually in a fashion the plaintiff disputes, based on this Court's holding in *Pilot Life*, 481 U.S. at 54, that Congress intended plan administration issues to be resolved through actions under ERISA rather than under the distinct laws of the several States.

2. In an attempt to shore up the *bona fides* of the decision below, and to minimize the stark split between its holding and reasoning and the otherwise-unanimous approach of the lower federal courts, respondents claim support from a set of cases that involved alleged negligent hiring and supervision of physicians by HMOs and/or vicarious liability claims. See Br. in Opp. 12.

According to respondents, these cases — which held that vicarious liability and negligent hiring/supervision claims are not completely preempted under Section 502(a) — support the decision below because, like this case, they involved "no request for and denial of benefits." *Ibid.*

The cases respondents rely on are clearly inapposite. In each, the challenged conduct involved the direct provision of medical services, either by the doctor herself — for whom the HMO was claimed to be vicariously liable — or by the HMO through the hiring and supervision of a physician. For example, certain claims in *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995), were held not to be completely preempted because they were based on the HMO's conduct in "provid[ing], arrang[ing] for, or supervis[ing] the doctors who provide the actual medical treatment." *Id.* at 360. In *Lupo* v. *Human Affairs International, Inc.*, 28 F.3d 269 (2d Cir. 1994), the HMO was claimed to be liable for its negligence in employing a psychotherapist who engaged in negligent treatment of, and misused privileged information from, a plan beneficiary. *Id.* at 272. In *Rice* v. *Panchal*, 65 F.3d 637 (1995), the HMO was claimed to be liable under a *respondeat superior* theory for the alleged malpractice of a plan doctor. *Id.* at 645. In *Giles* v. *NYLCare Health Plans, Inc.*, 172 F.3d 332 (5th Cir. 1999), plaintiffs claimed that the HMO was liable for a physician's failure to diagnose a heart defect on theories of vicarious liability and negligent selection of the physician (and the HMO did not even argue that complete preemption applied). *Id.* at 335, 338-339 & n.15. And in *Pacificare, Inc.* v. *Burrage*, 59 F.3d 151 (10th Cir. 1995), the claim was based on the HMO's alleged vicarious liability for its physician's negligent medical care. *Id.* at 155. Not one of those cases addressed whether Section 502(a) completely preempts a claim against an HMO based on the HMO's decisions about what medical care it would ***pay for*** — *i.e.*, the HMO's plan administration — rather than the HMO's liability for the doctor's negligent provision of medical care or the HMO's own negligent hiring and supervision of the

doctor who provided medical care.[4] Not one, accordingly, provides support for the decision below.

3. Respondents sum up (Br. in Opp. 14-15) by claiming that the Third Circuit "elucidated two tests courts can apply" to see whether a specific claim is preempted. Whatever might be said about whether the tests articulated by respondent would be a sensible overall approach to Section 502(a) complete preemption, they bear little relation to what the court of appeals actually did. As we showed above, the lower court's actual decision and reasoning are irreconcilable with the holdings and analysis of other courts. Without this Court's clarification, these conflicting holdings will lead to even more confusion about the proper scope of ERISA preemption. As one commentator recently noted, complete preemption under Section 502(a) remains a "pandora's box." Comment, *Closing the Lid on Pandora's Box: ERISA Preemption of Tort Actions Against Managed Care Organizations in State Courts*, 54 U. MIAMI L. REV. 373 (2000). Only this Court can close that box, and unify the disarray of the lower courts.

CONCLUSION

The petition for a writ of certiorari should be granted. In the alternative, the petition should be held and disposed of as appropriate in light of this Court's disposition of *Pegram* v. *Herdrich*, No. 98-1949, and *United States Healthcare Systems, Inc.* v. *Pennsylvania Hosp. Ins. Co.*, No. 98-1836.

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[4] Respondents alleged in their complaint that U.S. Healthcare was liable on a vicarious liability theory and on the basis of its alleged negligence "in failing to exercise due care in the selection, supervision, training, and/or monitoring of Dr. Nemeh as a participating provider of health services." Pet. App. 50a. We are not arguing that those claims are completely preempted under Section 502(a).

Respectfully submitted,

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MAY 2000